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Housing, mental health, and homelessness:
Exploring lived experiences of homelessness to identify barriers
to sustainable housing for vulnerable populations.

A thesis
submitted in partial fulfilment
of the requirements for the degree
of
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Abstract

Homelessness has become a much talked about topic in Aotearoa New Zealand in 2018 and the preceding years. This thesis explores the experiences of five people who have mental illness and have lived experience of homelessness in Aotearoa New Zealand, and two staff members who work closely with people who experience both mental illness and homelessness. The theoretical frameworks that inform this thesis are narrative research, social constructionism and humanistic psychology. Particular attention was paid to using theoretical frameworks and interview methods that suited Māori (the indigenous population of Aotearoa New Zealand) due to the inequities experienced by Māori in mental health and homelessness, and the majority of participants identifying as New Zealand Māori. Participants' narratives were gathered using semi- structured interviews. This study argues the importance of a humanistic perspective being used for research on homelessness. In contrast to traditional psychology, humanistic psychology emphasises respecting individual participants' voice and narratives about their personal experiences of homelessness while considering the environment that influence these narratives. The participants' narratives reflected their desire to be viewed as more than their life circumstances and illness through the sharing of their life stories. While there has been growing public awareness about mental illness, stigma still exists about mental illness which influences social narratives and how people who have mental illness understand their experiences. I argue that people who are vulnerable to homelessness, like those who experience mental illness, should have better protection from homelessness. To achieve this, I argue that structural barriers to finding, gaining and sustaining housing need to be addressed,

including the design of welfare and housing services. Additionally, there needs to be recognition that the solutions to homelessness are complex and require a whole of system approach to effectively address and prevent homelessness. Recognising the complex nature of homelessness and its solutions will help bring a focus to establishing predominantly preventative solutions while also providing emergency housing for people in need.

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Māori translations

Aotearoa – Māori word for New Zealand. Can be translated to land of the long white cloud.

Tangata whenua – The indigenous people of Aotearoa New Zealand

Te Tiriti o Waitangi – The Treaty of Waitangi, Aotearoa New Zealand's founding document.

Whakapapa – Genealogy

Tikanga – To follow best Māori custom

Whare tapa wha – Māori model of wellness developed by Mason Durie

Taha tinana – Physical health

Taha hinengaro – Emotional health

Taha whānau – Family health

Taha wairua – Spiritual health

Manaakitanga – Hospitality, generosity and showing care for others

Te Ara Tika – Best practise guide for Māori research

Whakawhanaungatanga – Process of establishing reciprocal relationships

Koha – Donation

Whānau – Family

Matakite – Māori giftedness or prophecy

Ta moko – Traditional facial tattoo

Puhoro – Traditional tattoo on thigh or arm

Mana – Power and prestige

Iwi – Extended kinship group or tribe

Marae – the open area in front of the wharehau (meeting house), where formal greetings and discussions take place. Central in Iwi relationships and events.

Chapter One: Introduction

In 2018, in Aotearoa New Zealand housing and homelessness have become much talked about topics. For researchers who work in the area of homelessness the poor state and availability of housing in Aotearoa New Zealand is not a new topic of conversation (Al-Nasrallah et al., 2005; Amore & Howden-Chapman, 2012; Bellamy, 2014; Hodgetts, Stolte, & Groot, 2014; Hodgetts, Stolte, Waimarie Nikora, & Groot, 2012; Maesele, Bie, & Roets, 2014). Studies in the 1980s featured these issues and advised government and policy makers to make changes on a systemic level to try and plan for pressure on housing (as cited by Mills et al., 2015). This message has been consistently reinforced by researchers who have stressed that there needs to be a long-term plan that addresses the causes of homelessness rather than a focus on short term crisis responses (Al-Nasrallah et al., 2005; Amore, 2016; Mills et al., 2015; Parsell & Marston, 2012). This lack of future planning puts vulnerable populations at the greatest risk of homelessness and housing insecurity. People who experience mental illness are among this vulnerable group.

Vulnerable populations are significantly affected by the current housing climate in Aotearoa New Zealand. The price of rental housing has increased at a faster rate than wages (A. Johnson, 2017a). Those who rely on income from Work and Income, including members from vulnerable populations, have had very small increases in benefits and no increase of the maximum housing supplement since 2009 (Ministry of Social Development, 2017a). Auckland rents have increased by 25% since 2011, this is the greatest increase in rents nationally. However, other regions have also experienced increases (A. Johnson, 2017a). In the Waikato

region, where this study took place, rents increased 9% in the year 2016 alone (A. Johnson, 2017a). This drastic increase in rent creates vulnerability to homelessness. These are not new issues in Aotearoa New Zealand. In 1982, Percy a researcher working in Auckland, concluded that the high cost of private rentals in comparison to income was one of the key causes of homelessness in Auckland (as cited by Mills et al., 2015). The more recent rapid increases in rent are caused by a complex combination of factors. Some of the factors that contribute to this increase are Aotearoa New Zealand's population increasing faster than the housing stock, investor behaviours, and the construction industry (Eaqub & Eaqub, 2015). In 1987, Thorns emphasised the need to address homelessness at a systemic level, and recommended increasing housing supply rather than adding temporary solutions such as emergency and shelter accommodation (as cited by Mills et al., 2015). Despite the recommendations made to respond to these issues over the past thirty years, there has still been little progress made in improving the housing situation in Aotearoa New Zealand.

The current study investigates the relationships between housing, mental health and homelessness. In this research, I explored the narratives of people with lived experience of homelessness and mental illness to try and better understand the barriers that they encounter in their attempts to find, gain and sustain housing. To provide a more nuanced view of housing, mental health, and homelessness, I also interviewed staff members who supported people while they were experiencing homelessness and mental illness. The study aims to provide the reader with a better understanding of the complex nature of homelessness and the importance of protecting vulnerable populations, like those with mental illness, from sliding into homelessness.

This chapter provides an overview of pertinent information about mental health, housing and homelessness. To do this, I begin by defining what is meant by the term homelessness and how the concept of home differs from housing. I also begin by defining what is meant by the terms mental health and mental illness. Since no social issue occurs in isolation, I will also introduce the reader to the current housing policy and political orientation of Aotearoa New Zealand. The chapter will then explore the historic link that exists between discussions about mental health and homelessness. This linkage has become more evident following the introduction of deinstitutionalisation, so the principles and consequences of deinstitutionalisation are then discussed. The chapter then discusses the connections between mental health and homelessness and the social determinants of health, especially poverty. I will end the chapter by discussing the inequities experienced by Māori, the indigenous population of Aotearoa New Zealand, in both mental health and homelessness to provide an understanding of the importance of culturally appropriate methods to research and service delivery to reduce these inequities.

1.1 Defining homelessness

Over the years and within different contexts, there have been many definitions used for homelessness. Traditionally, the word homeless has been used to describe a person living in public spaces. A more extensive definition used by Statistics New Zealand defines homelessness as “living situations where people with no other options to acquire safe and secure housing: are without shelter, in temporary accommodation, sharing accommodation with a household or living in uninhabitable housing” (Statistics New Zealand, 2009, p. 6). This definition of homelessness stretches to include hidden homelessness. Hidden homelessness

includes those who are couch surfing, staying with family, living in cars, living in garages, and living in overcrowded housing. I have used this more extensive definition of homelessness for this study.

Homeless people are not a single homogenous group. While homeless people are characterised by their lack of suitable shelter, their experiences can vary based on their social positionality. Hodgetts et al. (2012) draw on class distinctions and use the terms drifters and droppers for two different sub-groups of homelessness. Drifters are people who have lived in poverty for much of their life. Because drifters have lived in poverty, becoming homeless does not seem like such a dramatic change for them. Droppers, often come from backgrounds where they have not experienced extreme poverty. They drop into homelessness because of a specific life event, for example the loss of a job or the end of a relationship. Droppers often do not stay homeless for long lengths of time, but instead drop in for a short period and then will use social connections and other resources to help them access housing again.

1.2 Defining mental health

Mental health is a broad term that covers more than just the absence of mental illness or disability (World Health Organization, 2014). Mental health is used to describe a state of well-being where a person is able to function at the best of their abilities. In contrast, poor mental health is used to describe the worsening of a person's mental health but does not extend to the development of mental illness. In the current study, the term mental illness is used to describe a diagnosed psychological condition that a person may experience. Other words that are often used to describe mental illness are mental disorders, mental health concerns or mental health issues. Mental illness has been acknowledged as a form of disability

(Statistics New Zealand, 2014), and this disability contributes to people with mental illness being recognised as a vulnerable population (Mills et al., 2015).

1.3 Home or housed

While housing is important, Veness (1993) believes that to help people to sustain housing we need to understand and acknowledge the differences between housing and home. Traditionally, it has been assumed that a house provides the same as the concept of home, but these are two very different things. Housing is the physical structure in which a person lives, whilst home is a place that a person feels connected to (Veness, 1993). Home is usually a place where a person feels a sense of familiarity, comfort and belonging. Often these feelings are due to development of community integration, which can increase a person's sense of connection to their house and help it to feel like a home. Recent research states that developing community integration within neighbourhoods is key to helping a person maintain housing and thus strengthening the sense of home (Gabrielian, 2016). Community integration for people who experience mental illness can be achieved through either the normalisation of people within the general community or the creation of a subculture that provides buffering from stigma as people become part of, for example, a mental health community (Pahwa, 2014). Additionally, community integration not only helps support sustained housing and home-making, but can also improve people's mental health (Pahwa, 2014). Due to the links between community integration and a person's ability to create a sense of home, it's influence on sustained housing, and it's influence on mental health it is a very important concept in this study.

To better understand the barriers to sustained housing it is important to acknowledge the diversity of the homeless population and the diversity of their

needs. Not all people define home in the same way. In Aotearoa New Zealand, a disproportionate number of people who experience homelessness belong to the indigenous population of Māori. For Māori a sense of belonging is intricately connected to their ancestral lands, which impacts on how the indigenous population of Aotearoa New Zealand conceptualises and understands home (Tomlins Jahnke, 2002). For Māori, home may be seen as their ancestral home-place rather than the place and buildings in which they live. Māori connect their identity to their Iwi (tribe) and the nature, mountains, and rivers of their ancestral home-place. A secure connection to an ancestral home-place creates, strengthens, and maintains a sense of cultural identity which has been shown to support wellness (D. Johnson, Hodgetts, & Nikora, 2013; Tomlins Jahnke, 2002). In Aotearoa New Zealand, colonialism has meant that many indigenous people have lost their connection to their whakapapa, or genealogy, and ancestral home. The confiscation of land by Europeans, family dislocation, cultural dislocation, forced assimilation, and urbanisation have all had deep and lasting impacts on Māori people. The ongoing impacts of colonialism on Māori will be discussed in more detail later in this chapter.

1.4 A brief introduction to housing and homelessness policy

This section will focus on the policy that has been used in Aotearoa New Zealand and other countries within the Organisation for Economic Co-operation and Development (OECD), to try to address housing and homelessness. In Aotearoa New Zealand, housing and homelessness are seen as two separate issues. This is demonstrated by the lack of a comprehensive housing policy agenda in Aotearoa New Zealand for addressing homelessness (A. Johnson, 2013). Social narratives around homelessness create the perception that homelessness is a personal issue

or lifestyle ‘choice’ and not as something the State should have responsibility for (Widdowfield, 2001). The lack of monitoring of the prevalence of homelessness in Aotearoa New Zealand has also been responsible for allowing homelessness to be a significant gap in the policy process (A. Johnson, Howden-Chapman, & Eaquad, 2018; Leggatt-Cook & Chamberlain, 2015). In recent years, money has been invested to try and address homelessness, but there has been no robust evaluation of whether the funding that has been given to interventions for homelessness is actually reducing homelessness. Without baseline data about homeless populations the extent of the issue is very hard to measure going forwards (A. Johnson et al., 2018). Mainstream media tend to downplay the complexity of homelessness. Instead, housing issues are constructed as simply being a problem of a supply that can be resolved by freeing up more land for development as is shown in an article by Guy (2017). Media articles influence the social narrative that exists around homelessness and can contribute to creating reductive social narratives that do not reflect the complexity of homelessness.

The disconnect between housing and homelessness policy could be explained by the social narratives that exist regarding homelessness. Existing narratives either focus on the personal responsibility and failings or on the idea that homelessness is a structural issue (Buck, Toro, & Ramos, 2004; Gowan, 2010). By failing to combine housing and homelessness policy the other complex factors like poverty or economic structures may be excluded. However, if Aotearoa New Zealand’s government were able to create policy where multiple agencies, for example the Ministry of Social Development and Ministry of Health, worked together to address the structural factors that create homelessness we would also see benefits in health and other outcomes. Although there have been

some shifts in housing policy in recent years to try and reduce homelessness levels, the structural factors that continue to increase levels of homelessness have not had enough focus. This is despite academics having longstanding agreement that addressing the structural factors of poverty, economic structures, and the housing supply is fundamental in addressing homelessness (Early, 1998; Parsell & Marston, 2012). A wider view needs to be applied to policy development so that there is a joined-up approach between agencies that acknowledges the complexity behind the causes of, and solutions to, homelessness.

Housing policy in Aotearoa New Zealand has historically focussed on home ownership. This policy generally benefits those who are in a higher income bracket (Mills et al., 2015). With the rise in housing costs in Aotearoa New Zealand, it is uncertain whether the next generations will have the opportunity to own their own home. Instead, more people may spend their life renting (Eaqub & Eaqub, 2015). People in lower income brackets have been protected in the past by the relatively high rate of social housing available in Aotearoa New Zealand. However, in the two years between 2015 and 2017 Aotearoa New Zealand's social housing stock was decreased by almost 4000 houses (Housing New Zealand, 2015, 2017). This decrease in social housing stock has occurred during a time where there have been substantial increases in the number of people on the waiting lists for social housing. During this same time period, people on waiting lists for social housing increased from 3,399 to 5,353 (Ministry of Social Development, 2017b). These increases in social housing applications reflect how the rapidly rising housing costs alongside the reduction of social housing stock have affected the ability of people on low incomes to find and sustain suitable housing. Hence, they are at greater risk of homelessness.

Rising housing costs and the lack of affordable housing have contributed to Aotearoa New Zealand's high rates of homelessness. In the 2013 census, Aotearoa New Zealand had the highest rates of homelessness per head of population within the OECD countries with a rate of 1% (Amore, 2016). In other OECD countries, a range of policies are used to create rent pricing stability, including tax breaks for people to build housing, protection of tenants, and social housing available for those under an income bracket. Salvi del Pero, Ferraro, Frey, and Adema (2016) discuss many methods currently used to try to create good-quality and affordable housing. While there were no firm conclusions made on the best methods to improve access to housing, one conclusion that was very clear was that housing policy alone may not be able to influence factors like the reduction of poverty, income redistribution, and social integration, which are all integral in addressing the slide into homelessness (Salvi del Pero et al., 2016).

Aotearoa New Zealand has an aging population and increasing rates of people living with disabilities (Statistics New Zealand, 2014). A. Johnson (2017b) predicts that this will mean an increase in vulnerable populations who will require support for housing. Without robust planning for this increase in demand on housing support, there will be a continuing increase in homelessness and housing insecurity in Aotearoa New Zealand. Mills et al. (2015) argues that there should be an increase in social housing to try and compensate for this growth in need. The Housing Shareholders' Advisory Group (2010) agrees that increased social housing is needed, but that the government should be forging partnerships with Non-Government Organisations (NGO) who would build and manage social housing. In the current economic structure, NGO often do not have the resources or capacity to manage such a significant social investment (Hackworth & Moriah,

2006). Social housing is currently seen as not being financially sustainable, which would raise concerns for NGO being approached to take over the service. An example of the privatisation of social housing in Ontario, Canada found that it created additional financial burdens on the NGO social housing sector (Hackworth & Moriah, 2006). In Aotearoa New Zealand, financial unsustainability of social housing is caused by the Housing New Zealand Corporation¹ being required to pay massive dividends to the government (A. Johnson, 2013). This financial pressure has crippled the agency, and has created the rationale for a concerted programme of selling and privatising state housing stock. The focus on profits appears to be politically-motivated, since this is not a requirement or standard that is applied to other forms of public investment. In fact, even private landlords receive tax credits for supplying housing, which are not given to the social housing sector (A. Johnson, 2017a). If the government applied less of a focus on financial profit and more of a focus on social benefits, social housing could be valued for achieving its key purpose; to support those most vulnerable to poverty and homelessness (Amore, 2016; A. Johnson, 2017b; Keall, 2010).

Homeownership has been decreasing in Aotearoa New Zealand, and there is a move towards more people continuing to rent throughout their life (Eaqub & Eaqub, 2015). This poses an issue for many people's health due to the poor protection of renters in Aotearoa New Zealand (Keall, 2010). The quality of many rental properties within Aotearoa New Zealand is substandard and has been identified as a public health issue (Philippa Howden-Chapman & Chapman,

¹ Housing New Zealand Corporation is a Crown agent that provides social housing services.

2012). Houses in Aotearoa New Zealand are often damp, cold, and mouldy because of their poor insulation, poor ventilation, and lack of adequate heating, which often leads to high rates of respiratory conditions (P. Howden-Chapman et al., 2005). Because of these issues, Keall (2010) has suggested that there is a need for better policy to be utilised to protect tenants, including a rental warrant of fitness². Vulnerable people with low-incomes often struggle to access quality accommodation, so they end up living in cold and damp houses, which harms their health (Mills et al., 2015). Such vulnerable groups are often less likely to complain about the condition of their housing. The fear of being evicted from their tenancy or increases in rent act as barriers to them speaking out about issues that they are experiencing with the standard of their rentals (Mills et al., 2015). The introduction of the rental warrant of fitness and policies for better protection for tenants are necessary steps for advances in public health (Philippa Howden-Chapman et al., 2012), and for the protection of vulnerable people with low-incomes and limited housing options.

There are two main rehousing interventions that are used to try to respond to homelessness. The first is, supported living with a step-by-step programme to rehousing and the second is, Housing First. Supported living programs usually have a reducing level of support over set lengths of time and will have strict criteria of entry (usually drug free) and strict rules that people must follow to remain in the programme. This intervention has high levels of recidivism due to the strict guidelines and inflexibility of timelines (Johnsen & Teixeira, 2010). In

² A rental warrant of fitness was developed by public health experts in Aotearoa New Zealand to try and improve the quality of rental housing (A. Johnson et al., 2018). It demands the installation of insulation and decreased moisture in rental properties. The previous government was resistant to enforcing a rental warrant of fitness but in December 2017 the Healthy Homes Guarantee Act was passed, and will be enforceable by 1 July 2024, to improve the condition of rental housing (Robertson, 2018).

contrast, Housing First is a lot more flexible and sees housing as a basic human right and that all people are deserving of housing (Chernega & George, 2014). This intervention is generally implemented by NGO that are involved to provide support and services to the people once they are housed. Housing First has been shown to decrease hospitalisations, hospital days and emergency room presentations (Chernega & George, 2014; Gladwell, 2006). It is more cost effective to treat a person's health concerns, whether these are physical, mental or addiction issues, when a person is housed (Chernega & George, 2014). Although both of these housing interventions have shown success in some areas, they limit their focus to homelessness at an individual level and do not address the systemic factors that often lead to homelessness.

1.5 Political environment and neoliberalism

Neoliberalism is a modern extension of liberalism that was developed in the 17th and 18th century (Labonte & Stuckler, 2016). Proponents of neoliberalism argue that the economy is too complex to control, so governments should not intervene in the markets (Labonte & Stuckler, 2016). It is assumed that the markets will then moderate themselves through free trade. Furthermore, neoliberalism emphasises individual responsibility over state responsibility, so neoliberal orientated countries have seen a shift where social protection has been minimised through the reduction of social housing and welfare assistance (Hackworth & Moriah, 2006; Labonte & Stuckler, 2016; Sparke, 2017). Consequently, neoliberalism has been linked to poorer health outcomes, higher levels of economic inequality, poorer quality of life, and higher levels of unemployment (Farrugia & Gerrard, 2016; Labonte & Stuckler, 2016; Schrecker & Bamba, 2015; Sparke, 2017; Springer, 2016). Neoliberalism was introduced to Aotearoa

New Zealand politics in the 1980s when a financial crisis encouraged politicians to move towards a small state approach to government in an effort to save money (Roper, 2005). The consequences of the 1980-1990s extreme neoliberal policies are seen in Aotearoa New Zealand's current social protection policies (Prussing & Newbury, 2016). In 2016, Aotearoa New Zealand ranked below average in social spending among OECD countries (OECD, 2016).

Neoliberalism affects housing through the free market principles that are applied to the housing market (Farrugia & Gerrard, 2016). These principles encourage investors to become involved in the market, driving the prices of houses up and creating a speculative bubble (Eaqub & Eaquad, 2015). Increases in house prices lead to larger mortgages, which drives rental prices higher in order to cover mortgages repayments for properties. Having less government involvement in markets means there is inadequate monitoring of the housing stock available to the market. This lack of monitoring of housing stock has meant that the government has not been able to be proactive and plan for the increases of net migration being larger than housing stock increases (A. Johnson et al., 2018).

Neoliberalism affects homelessness through the reduction in state housing and insufficient welfare support (Farrugia & Gerrard, 2016). Neoliberalism promotes an increased focus on individualised responsibility and reduction in social support (Farrugia & Gerrard, 2016). Due to the reduction in social support people who rely on welfare payments to help pay for housing may not be able to afford housing. This is in part due to the increased housing costs caused by neoliberalism, as discussed above (Eaqub & Eaquad, 2015). Not only are people socially excluded because of financial and housing hardships, but also the social

narratives that exist. These social narratives are influenced by the individualised responsibility prioritised in neoliberalism and shape the narratives about an individual's slide into homelessness (Farrugia & Gerrard, 2016). Furthermore, the dominant social narratives that have developed in many societies today, typically suggest homelessness is solely a personal issue or lifestyle 'choice', and not as something the State should have responsibility for (Hodgetts et al., 2012).

1.6 Mental health and homelessness

Homelessness and poor mental health are interconnected issues. One third to half of the homeless population are estimated to experience "disabling mental illness" (D. Johnson et al., 2013). The rates of mental illness is higher for people who experience homelessness than rates experienced by the general population (D. Johnson et al., 2013). Such vulnerable people are more susceptible to homelessness because they have fewer resources available to counter the conditions of poverty (Pleace, 1998). Early (1998) proposes that people who experience mental illness find the process of obtaining and maintaining accommodation, including the contracts and meeting with the landlords, as a barrier to sustained housing.

O'Connell (2004) claims that people who experience mental illness are not only limited by poverty when it comes to housing selection and choice, they are limited by their illness itself. Homelessness can amplify illness, which means that people are more likely to get more acutely ill and have increased frequency of episodes of both physical and mental illness. This consequently leads to homelessness and mental illness being linked with decreased life expectancy (Amore & Howden-Chapman, 2012). Additionally, homelessness increases the complexity of managing chronic illnesses such as mental illness (Gladwell, 2006;

A. Johnson, 2013; Keall, 2010; O'Connell, 2004; Stolte & Hodgetts, 2015).

Important and seemingly basic tasks like managing and safely storing medications can be an issue for people without a stable abode. Homelessness is harmful to a person's mental health as it is corrosive to their sense of self-worth, and erodes their dignity (Stolte & Hodgetts, 2015). Homelessness is very stressful and unsettling, so can lead to a period of poor mental health for a person who might already have a pre-existing mental illness or for those who may be predisposed to mental illness. For those trying to maintain their health on the streets, mainstream health services are not always accessible as they are based on the assumptions of a domiciled perspective, and they are not always user friendly for people experiencing homelessness (Stolte & Hodgetts, 2015). As well as experiencing decreased accessibility of services, people who are homeless may just not see accessing health services as a high priority when compared to other basic human needs like shelter and food (Stolte & Hodgetts, 2015). Due to having poor access to services and poor environmental conditions, the homeless population experience massive health inequities and have a reduced life expectancy (Chernega & George, 2014). Improvements in outcomes for vulnerable populations, such as those who experience homelessness, could include healthcare and housing services be delivered as a basic human right that should be accessible to everyone (Rasanathan, 2010).

While mental illness can be exacerbated by housing instability, there is also a link between poor mental health and difficulties obtaining housing due to the stigma that exists about mental illness (Alden, 2015; Amore & Howden-Chapman, 2012; Frederick, Chwalek, Hughes, Karabanow, & Kidd, 2014; Maesele et al., 2014; Vásquez-Vera et al., 2017). In the current Aotearoa New

Zealand context, where a housing crisis exists, landlords are able to pick their tenants from a long list of applicants (A. Johnson, 2017b). The stigma that exists around mental illness can mean that people who are identified as a mental health service user are typically at the end of the queue when trying to secure tenancies. This stigma can be limiting for people when they are trying to find accommodation, and they might experience discrimination because of their mental illness (Schneider, 2010). These experiences of discrimination impact on people who live with mental illnesses and reduce their ability to attain a home.

1.7 Deinstitutionalisation

Deinstitutionalisation of mental health institutions was a process that began internationally in the 1980s (Brunton, 2003; Dear & Wolch, 2014; Novella, 2010).

In Aotearoa New Zealand, this process took place in the late 1990s. In the Waikato District, where the research used to inform this study took place, the mental health institution Tokanui was closed in 1996 (Swarbrick, 2015).

Deinstitutionalisation was based on the principles of liberty, choice, homely choice, and social acceptance (Brunton, 2003). The aim was to move people from institutions into a community care model, so that people were more integrated into society and had more choice and control. Studies in Australia have questioned whether there was enough planning put into the relocation of people (Drake, 2014). In Australian studies, researchers have argued that the process was actually a trans-institutionalisation as people were moved from mental health institutions into hostels and shelters. In Aotearoa New Zealand deinstitutionalisation was not as harshly criticised as in other countries, but a significant proportion of the homeless population in Aotearoa New Zealand experience serious mental illness

(Amore & Howden-Chapman, 2012). This situation suggests that the deinstitutionalisation of mental health facilities could be related to homelessness.

1.8 Social determinants of health

The social determinants of health were first formalised in a global agreement in 1978 in the Alma Ata Declaration. The Alma Ata Declaration was written by the World Health Organisation and discussed the importance of looking beyond the medical model and also considering societal factors in determining if a person will be healthy. In 1998, Wilkinson and Marmot published 'The solid facts' an education paper that focussed on ten brief messages to try and inform policy makers and public health workers on the social determinants of health. Wilkinson and Marmot (1998) identified the ten most important social determinants of health as the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport. Other key social determinants of health that have been recognised since are poverty and housing (Keall, 2010; Topor et al., 2014). Recent studies also conclude that the social determinants of health are extremely important and should be considered at all levels of health and social services (Silva, Loureiro, & Cardoso, 2016). Mooney (2012) concludes that the social determinants of health are more important determinants than health care. Furthermore, inequality and poverty are now seen as the greatest determinants of health. Growing inequalities are linked to the rise of neoliberalism and its resistance to controlling the economic environment, moves toward privatisation, and reduction in social supports. All of these factors have contributed to growing inequalities and poorer health outcomes (Labonte & Stuckler, 2016).

Poverty and disadvantage are the main causes of homelessness (Amore & Howden-Chapman, 2012; Parsell & Marston, 2012). In addition, unaffordable housing can create poverty (Yinger, 2001). Poverty leads to poor health outcomes because poorer people tend to have adverse living environments, increased stress, and more limited access to health services (Burns, 2015). People who experience poverty often have a restrained ability to participate in ‘normal’ activities in the society that they live, and this can lead to social exclusion. Social exclusion is also linked to both homelessness and mental illness because people are excluded from ‘normal’ activities within society. People who experience mental illness often are more socially excluded because, in addition to reduced participation, they also experience discrimination and stigmatisation related to their illness (Yanos, Barrow, & Tsemberis, 2004). Burns (2015) suggests that development of social integration and participation should be part of mental health interventions because of their ability to improve wellness. Yet, this is perhaps not going far enough, as there is also a need for a public health imperative to reduce poverty by addressing housing, childhood adversity, physical health, and mental health (Amore & Howden-Chapman, 2012).

The overrepresentation of people with mental illness in the homeless population is also in part due to their lack of earning potential (Early, 1998). Employment is a social determinant of health that impacts on people’s day-to-day capacity to meet housing costs. In the 21st century, an increasing segment of the labour market has become characterised by low-pay and employment insecurity. People who are affected by employment insecurity and uncertain employment are becoming part of a class that Standing (2016) calls the precariat. The uncertainty of employment impacts negatively on a person’s physical and mental health. Not

only are people in the precariat class affected by uncertain employment, they also often feel a sense of social isolation, and have housing uncertainty. Standing (2016, p. 315) argues that ignoring the root causes of this new class - who experience insecure employment and housing, and social isolation - will lead to the precariat becoming “the dangerous class.” The experience of precariousness is ‘dangerous’ for the health of people concerned and their families, but it also leads to discontent and political instability, which can lead to danger for society (Standing, 2016).

As was discussed earlier in the introduction to housing policies and the current housing situation in Aotearoa New Zealand, housing is very important for the health of people. Housing has been identified as an important social determinant of health (Keall, 2010; O'Connell, 2004) and has been identified as a human right (UN General Assembly, 1948). All of us need housing to not only survive but thrive. Article 25 of the Universal Declaration of Human Rights (1948) states that

“everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age and other lack of livelihood in circumstances beyond his control.”

Housing is important to meet the material need for shelter. However, housing is also a fundamental psychological need in terms of providing safety and stability, and as a basis for people to feel a part of a community and wider society (Isogai, 2016; Yanos et al., 2004).

Feeling part of a community and wider society is part of establishing social support. Given that social support impacts on both mental health and housing, this social determinant of health is very relevant to the current study. The social supports that a person has available to them can also be described as social capital. Silva et al. (2016, p. 278) defines social capital as “the resources available to individuals and to society through social relationships”. People with more social capital tend to have a stronger buffer in the face of hardships and adversity (Pleace, 1998). Having more social supports provides psychological resources which reduces the likelihood of loneliness and isolation (Levula, Wilson, & Harré, 2016). Having stronger social supports can also provide material benefits, as a person may be able to call on friends and family to share their homes and resources when in need. People with disabilities often have reduced social capital, this is particularly true for those who have psychological disabilities or mental illness (Mithen, Aitken, Ziersch, & Kavanagh, 2015). Mithen et al. (2015) emphasise the importance of social policy that encourages the inclusion of people with disabilities, and the development of social capital so that people do not experience inequities related to reduced social capital and social exclusion.

Adverse childhood events are linked to increased chances of developing physical and mental illness (Sederer, 2016), which increases the risk of homelessness (Wilkinson & Marmot, 1998). For instance, children who have been in foster care are three to five times more likely to experience mental illness (Turney & Wildeman, 2017). Furthermore, foster care is often related to family instability, socio-economic disadvantage, and poorer neighbourhoods; these factors have also been linked to the higher rates of mental illness so may contribute to the higher rates of mental illness in children who go into foster care.

In Aotearoa New Zealand, childhood poverty and abuse are two adverse childhood events that occur far too frequently. Between seven to ten children are killed each year by their primary caregiver (Peters & Besley, 2014). As well as high rates of childhood abuse, Aotearoa New Zealand also has high rates of childhood poverty. UNICEF Office of Research (2017) states that 20% of Aotearoa New Zealand children grow up in poverty. Childhood poverty, like all other social determinants of health, have been significantly impacted by the global rise of neoliberalism, this has led to increases in poverty worldwide (Peters & Besley, 2014; Schrecker & Bamba, 2015).

The social determinants of health overlap and can compound disadvantage and poor health outcomes. Housing affects poverty, poverty affects housing, poverty affects adverse childhood events, housing instability affects adverse childhood events, social capital affects poverty, and all affect health. Improving health should be a key goal for all governments as health is a fundamental human right (World Health Organization, 2015).

1.9 Social narratives about poverty

Historically, poverty has been viewed as a moral issue rather than an economic issue (Schneider, 2010). This narrative has arisen so that people who live in poverty can be blamed for their own circumstances. Today, people who live in poverty experience this same narrative, because of this people may internalise stigma, which in turn reduces self-worth as they come to believe that their poverty is a personal failing (Burns, 2015). People who become homeless and are therefore at the most extreme level of poverty, experience the narrative that this is due to personal failings, illness, or dependencies. In contrast to such individualised explanations, research suggests that increasing rates of

homelessness are instead related to reduced spending on mental health services; reduced spending on welfare; reduced access to social housing and an overall reduction in housing stock (A. Johnson et al., 2018; Pleace, 1998). The view that those who live in poverty do so because of individual failings, has also contributed to the discursive construction of (un)worthiness for assistance from social welfare including income and housing. Social welfare agencies are able to choose who, when, and how people receive help. This often means that only those who are viewed as being moral or worthy get the assistance they need (Pleace, 1998). Schneider (2010) notes that this is also true for people who have mental illness when they are being assessed for housing support; the staff members get to decide who is “worthy” of help. Many of the participants involved in the research conducted for this thesis have encountered such judgment, and it has impacted on their ability to find accommodation.

1.10 Inequities for Māori

Māori are overrepresented in both mental health statistics and homeless populations within Aotearoa New Zealand. For this reason, it is important to acknowledge and strive to understand the historical factors that have influenced these inequities. Understanding the historical trauma that has occurred, and forming strategies to create equitable opportunities and representation of Māori, is important to help create better outcomes for Māori in the future.

Māori are the tangata whenua or indigenous population of Aotearoa New Zealand. In the recognised founding document of Aotearoa New Zealand Te Tiriti o Waitangi, Māori are promised partnership, protection, and participation by the Crown. During the process of colonialism, the rights and promises made in Te Tiriti o Waitangi were not recognised, and instead Māori experienced land

confiscation, forced acculturation, forced assimilation, social marginalisation, political oppression, and devastating population decline with increased morbidity and decreased life expectancy (Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Bennett, Flett, & Babbage, 2016; Came, McCreanor, Doole, & Simpson, 2017; Durie, 1999; Furness, Nikora, Hodgetts, & Robertson, 2016; Hudson, Milne, Reynolds, Russell, & Smith, 2010; D. Johnson et al., 2013; Mokuau & Mataira, 2013; Prussing & Newbury, 2016; Rochford, 2004; Simpson, Adams, Oben, Wicken, & Duncanson, 2014; Tomlins Jahnke, 2002; Zambas & Wright, 2016). The effects of the colonisation process are still impacting on Māori education, health, crime, and housing outcomes today.

Māori experience inequities that can result in higher rates of cardiovascular disease, deaths from cancer, kidney disease, metabolic disorders, drug and alcohol abuse, and mental distress (Zambas & Wright, 2016). Māori are disproportionately affected by all mental illnesses and have higher rates of suicide than non-Māori (D. Johnson et al., 2013). Over their lifetime 50.7% of Māori report experiencing mental illness (Baxter et al., 2006). Although these statistics paint a decidedly negative picture for Māori, studies have shown that a strong cultural identity and knowing one's whakapapa can improve health outcomes for Māori (Tomlins Jahnke, 2002). According to Taonui (2015), whakapapa is

“a taxonomic framework that links all animate and inanimate, known and unknown phenomena in the terrestrial and spiritual worlds. Whakapapa therefore binds all things. It maps relationships so that mythology, legend, history, knowledge, tikanga (custom), philosophies, and spiritualities are organised, preserved, and transmitted from one generation to the next”(Taonui, 2015, para. 1).

In contrast to ‘western’ individualistic societies, who Māori people are connected to is more important than who they are as individuals (Tomlins Jahnke, 2002). Thus, being part of a web of connections and relationships is more important to the Māori self than simply advancing in life as an individual person. This means that being disconnected from whakapapa erodes the Māori sense of self, and can create a greater sense of social and cultural dislocation than for people from more individually orientated cultures (Tomlins Jahnke, 2002). Due to the importance of concepts like whakapapa, the government of Aotearoa New Zealand should strive to create services that embrace and encourage strong cultural identities since this would be beneficial for Māori health.

To try to improve Māori outcomes in the future it is important for services, policy makers, and researchers to try and incorporate Māori worldviews and practises into their interactions with Māori to create equitable opportunities for success. An example of this in the health sector is incorporating and acknowledging Māori models of wellness. Durie (1999) developed Whare Tapa Wha (four cornerstones of health), which discusses the many facets that contribute to health. Whare Tapa Wha looks at the four cornerstones of health - taha tinana (physical), taha hinengaro (emotion), taha whānau (social), and taha wairua (spiritual) (Rochford, 2004). There are many other models of health that have been created to reflect Māori worldviews, but this is the most well-known. Whare Tapa Wha links very closely to the social determinants of health because it acknowledges the importance of the social, spiritual, and emotional as well as the physical in the maintenance of health and wellbeing.

Māori also experience inequities when it comes to housing. Māori are less likely to own their own home, and are more likely to experience housing

instability (A. Johnson, 2017a). Furthermore, Māori are disproportionately affected by homelessness (D. Johnson et al., 2013). Recent studies have concluded that this lower rate of home ownership for Māori is linked to ongoing systemic racism against Māori, even going as far as stating that the more Māori you look the less likely it is that you will receive a mortgage (Carla & Chris, 2015). This underlying racism is pervasive through society and needs to be addressed. As one of the social determinants of health, housing can have a huge impact on wellbeing, as is discussed earlier in this chapter. Māori need to have equitable opportunities to access housing in order to improve wellbeing outcomes.

Using culturally appropriate approaches in health and housing is extremely important in order to give Māori equitable opportunities for flourishing. Reducing inequities for Māori requires a systemic approach that acknowledges the historical trauma faced by Māori and gives equitable opportunities for improvement in health and housing (Came et al., 2017). Acknowledging historical trauma is important because of the impacts that this is still having on Māori health, education, crime, and housing outcomes today. Alongside historical trauma, Māori face significant challenges because of the systemic racism that exists in Aotearoa New Zealand (Zambas & Wright, 2016). While individual experiences of racism can be dismissed, recent studies have shown that racism is widespread and pervasive in Aotearoa New Zealand (Carla & Chris, 2015). For inequities to be reduced for Māori, there needs to be a whole of system, radical change to how Aotearoa New Zealand delivers services and runs businesses in order to address growing inequities (Simpson et al., 2014). There needs to be a focus on Māori issues, needs, and worldviews through all services that are designed in Aotearoa New Zealand. Health and housing in particular, need to become more culturally

responsive to Māori needs, and should be designed in a way that encourages better engagement with Māori (Came et al., 2017; Tomlins Jahnke, 2002).

1.11 The current study

The current study involves qualitative research that used semi-structured interviews with people who have experienced homelessness and mental illness, and with staff members who support them. Seven people were interviewed; Five of whom have personally experienced homelessness and mental illness, and two were staff members who support this population on a daily basis. It was important to get the perspectives of people with lived experience of homelessness to better understand how to help. Recent reports about the state of housing capture the increasing pressure on housing in Aotearoa New Zealand, but fail to capture the voice of the people who are affected most - those most vulnerable to homelessness. A humanistic psychology perspective has been used to inform the view of this study. A key priority in doing this research, was to provide a voice that humanises each unique experience of the participants. I do not claim to generalise the findings to all humans, but instead I seek to respect the diversity of the participants and to understand their experiences.

The next chapter focusses on the methodology used through the study and the analysis of the information gathered. This is followed by two chapters of analysis of the data from the interviews. Lastly, chapter 5 discusses the conclusions, relating them to current literature, and identifies areas for further research.

Chapter Two: Methodology

This chapter provides the reader with an overview of the methodology used in this study. It will begin by discussing the theoretical concepts that have informed the development of the methodology. I will then explain the process that was used to recruit the participants. This study is qualitative in nature and semi-structured interviews were used to collect narratives from the participants. The process used will be discussed in more detail later in the chapter. Two groups of participants were recruited for the study. The first group includes people who experience mental illness and have experienced a period of homelessness in the preceding two years. The second group comprised staff who support people who fit within the requirements for group 1. Brief biographies are included to provide background information about the participants. Due to the vulnerability of participants in group 1, the steps taken to provide a safe environment for participants are discussed. The chapter will end with a description of the analysis process used to interpret participants' narratives.

2.1 How I came to this topic

I am a Pakeha female who grew up near the rural town of Matamata. Growing up, we lived approximately twenty kilometres from town and did not go into bigger cities often. When I was eighteen I decided to take a gap year and moved to Washington, District of Columbia. It was here in the United States of America that I was first made aware of, and had my first interaction with, people experiencing homelessness. I came home to New Zealand and completed a bachelors and post-graduate diploma in Psychology with a specific focus on Community Psychology. After my studies, I began working in an acute

community mental health service for the Waikato District Health Board (DHB). During my time working there, I was consistently awed by the resilience of people with whom I came into contact. The connection between homelessness or at least unstable housing with mental health became apparent very quickly. Through my job I was asked to support clients in finding accommodation. Some of the people that I supported were very unwell, which caused massive barriers for them in their search for accommodation. Even as a healthy person who had access to internet and a phone, I found the process of trying to access accommodation for people with mental illness, to be extremely hard. I would arrive at a rental property open home and there would be 15 people there competing for two rooms. These experiences, and my background studying community psychology, made me interested in trying to better understand housing insecurity and homelessness among people with mental illness.

2.2 Theoretical concepts that inform the study

The theoretical framework for this thesis draws on social constructionist theory. A social constructionist perspective acknowledges that all knowledge is created within a historical and cultural context (Yang & Gergen, 2012). Furthermore, knowledge is created through the lens of the creator's moralities, political environment, religious beliefs, and culture (Gergen, 2015). In addition to an individual's lens of history impacting on the construction of knowledge, it is also developed through the social sharing of these meanings. The contextually dependant interpretation of knowledge and meaning suggest that what is known can be described as only a subjective reality (Hjelm, 2014). Ultimately, social constructionist theory posits that all knowledge is created and transmitted socially, so what is known is based on the society that you live within (Hjelm, 2014).

Through this social transmission of knowledge we create social narratives about the world around us, which are to a considerable extent shaped by the perspective of the dominant culture (Hjelm, 2014).

Within societies there is a dominant social narrative constructed through socially created ideas. The dominant social narrative is usually based on the perspectives of those who have the most influence on information sharing (for example the mainstream media) or development of policy (Hjelm, 2014). In most cases, this means that knowledge or dominant social narratives are created from a middle and upper class perspective, and as a result society is typically not constructed to protect or support those in lower socio-economic groups (Mills et al., 2015). Participants' narratives must be considered in the context of the society they live in, and alongside the socially constructed dominant narratives that shape their personal narratives. There is a large academic literature base on the topic of homelessness. As is often the case with research, the topic is explored and analysed by researchers who have not experienced homelessness themselves. Although this lack of personal experience on researchers' behalf is perhaps unavoidable, it is important to gain insights into homelessness which go beyond an "outsider" perspective. The use of in-depth qualitative research methods offers researchers a way of gaining deeper understandings from the perspective of the person whose worldview is shaped by the context of homelessness.

This study is underpinned by the principles of humanistic psychology. Humanism emphasises the fundamental good inherent in every human being, and acknowledges that people are complex beings that are more than the combinations of their parts (Aanstoos, 2003). Humanistic psychology also acknowledges how a myriad of contextual factors (both in their micro and macro environments),

influence a person's development and worldview (Hardy, 2016). In humanistic psychological research, the objective is to diminish the worldview and interests of the observer (i.e. researcher), and to instead more accurately document the views of the people being researched. Consequently, humanistic psychology research aims to value the voice of participants, to allow them to shape their own narrative and share their truth (Hardy, 2016). According to D. Johnson et al. (2013), the use of a humanistic approach in psychological research on homelessness is a responsive and culturally appropriate way to highlight the consequences of existing societal processes that can result in some people becoming homeless. Consequently, humanism fits with the aim of this study, which seeks to improve understandings of the interconnections between mental health and homelessness, and to ensure that such people gain better support in their search for accommodation to maintain their wellness.

The research methodology and, in particular, the analysis is based on narrative health psychology. Narrative methodology allows researchers to use the stories of participants to provide insights into the broader meanings of how health and homelessness are experienced by the people who are affected (Crowe, Inder, & Porter, 2015; Hodgetts & Stolte, 2012). Narrative approaches to research and the semi structured interviews allow researchers to expand on participants' ideas about barriers to housing, barriers to wellbeing, and approaches that have been helpful in keeping participants well and in sustained housing in the past. Additionally, narrative approaches also allow for a focus on people's strengths and their resilience in tough situations. Highlighting people's strengths and resilience is important in the field of homelessness research, as traditionally homelessness has been presented as caused by personal inadequacies without

reference to the larger macro environment and social determinants of health that can compromise people's ability to sustain housing (D. Johnson et al., 2013). The narrative approach to health and community research also allows researchers to focus on other aspects of holistic wellbeing. A holistic approach aligns with Māori models of wellness like Whare Tapa Wha, which emphasise that health does not only include physical health, but should also include the spiritual, social, physical, and emotional wellbeing of people (Rochford, 2004). This holistic view of health is especially important for people accessing mental health services (Durie, 1999). Because of the importance of the physical and social determinants related to maintaining mental health, it is appropriate to use an approach that explores and highlights all the factors that impact on health.

In Aotearoa New Zealand, Māori are disproportionately affected by both mental illness and homelessness (Al-Nasrallah et al., 2005; A. Johnson, 2013; D. Johnson et al., 2013). Therefore, the theoretical concepts and research methods used in research focussed on homelessness and mental health should be culturally responsive, and allow for equitable opportunities for Māori to express themselves and their worldview (D. Johnson et al., 2013). Through utilising a narrative methodology while interviewing people, I have sought to value their narratives through respect for each participant's voice and their expert knowledge. This respect for participants along with my attempts to protect participants' anonymity and encourage family support during interviews, aligns with culturally responsive research practise as it demonstrates the practise of manaakitanga (Hudson et al., 2010). Manaakitanga is one of the concepts in Te Ara Tika mentioned as important for researchers to use when undertaking research with Māori

participants, and involves protection, participation and partnership within the research/participant relationship (Hudson et al., 2010).

The number of participants in this study is smaller than the number of participants in many quantitative psychology research studies. Small numbers of participants in qualitative case-based studies is not a limitation since the aim is not to find results that are transferable to the whole population studied. Instead, the aim is to understand the participants within their own contexts and not as a person removed from the world in which they exist (Sools, Murray, & Westerhof, 2015). Using a case-study approach enables researchers to view the impacts of wider socio-political settings and processes within the context of everyday lived experiences (Hodgetts & Stolte, 2012). Furthermore, the use of qualitative case-based research in these complex areas provides a deeper understanding of homelessness than just the frequency of occurrences that would be gained through quantitative research (Hodgetts & Stolte, 2012). Hodgetts and Stolte (2012) suggest that, in case-based research, a relationship needs to be made between the researcher and participant to encourage a deeper level of sharing, which also fits with Māori practise of whakawhanaungatanga or reciprocal relationship building (Hudson et al., 2010). According to Te Ara Tika, using the concept of whakawhanaungatanga in a research setting is fundamental for establishing a meaningful relationship between the researcher and participant, and this is essential for research involving Māori participants (Hudson et al., 2010).

2.3 Empirical work

Research process and recruitment

Two groups were recruited. The first group (which will be referred to as group 1) are people who have experienced homelessness in the last two years and who

experience mental illness. For the purposes of this study, homelessness, which was defined in the previous chapter, includes those who are couch surfing, living on the street, or living in an unsuitable housing situation (e.g. living in a three-bedroom home with fourteen other people, in a car or a garage). The second group of participants (which will be referred to as group 2), were staff members from agencies that interact with and support people (on a daily or weekly basis) who have mental illness and experience homelessness. Gender distribution was not a factor.

Participants from group 1 were recruited through the Waikato District Health Board (DHB) Community Mental Health Teams (CMHT). An email was sent to community mental health staff members, usually referred to as keyworkers, (see Appendix A), which asked them to identify any clients who met the criteria for taking part in the research. These keyworkers were also asked to approach and ask the clients for their consent to pass their details on to me. The email sent to keyworkers included a letter of invitation (see Appendix A) and an information sheet (see Appendix B). The information sheet included the purpose of the study, who the researcher was and what would be expected of the participants. These documents provided keyworkers with the ability to answer basic questions about the study, and meant that they could give information sheets to any potential participants.

There was a very low response rate from the email, so I then approached keyworkers in person to explain what my research was about and to ask them for help with recruiting participants. The process was then followed as described above, with the keyworker approaching potential participants and passing on their details. Potential participants were offered the opportunity to initially meet me

with their keyworker present. This allowed the client to gain more information about the research and researcher with the support of someone they had an existing relationship with (Furness et al., 2016). Participants were also offered the opportunity to have a support person present during the interviews. I discussed with participants what was required of them for the research, that their anonymity would be protected, and the consent process. Participants were told that they would receive a koha (donation) of a \$20 grocery voucher at the end of the interviews as a show of appreciation for their time and for sharing their knowledge (Thomas & Hodges, 2010). During this first contact, a time and place were arranged with the participants for the initial interview.

Group 2 included two staff members who, on a daily or weekly basis, support people who experience homelessness and mental illness. An email was sent to the Waikato DHB community mental health team managers and to Anglican Action (Appendix C). This email included an information sheet as an attachment (Appendix D). Anglican Action declined to be involved in the research as they work with recently released parolees who did not necessarily have mental health concerns. Instead, Anglican Action suggested that I should make contact with the Hamilton Christian night shelter given that their staff interact daily with people experiencing homelessness; a large percentage of whom also experience mental illness. An email (Appendix C) was then sent to the manager of the Hamilton Christian night shelter, which included an information sheet as an attachment (Appendix D). Responses were received from a social worker from the Waikato DHB Assertive Community Treatment Team, and the manager of the Hamilton Christian Men's night shelter who both agreed to participate in an interview.

Interviews

Interviews were conducted at a place and time agreed upon by both the participant and the researcher. Interviews were semi-structured with an interview schedule was used as a guide (see Appendix E and F). Demographic information, and additional details about the interview, location, time and suggested areas to expand on in future interviews, were recorded on the participant background sheet (Appendix G and H). A semi-structured narrative focused methodology was used during the interviews, as this method allowed the interviewer to explore any unexpected topics that came up. The other benefit of semi-structured interviews is that they allow for a more conversational style of interviewing, which can help to lessen the power relationships that are traditionally created through the researcher/participant relationship (Furness et al., 2016). Reducing power relationships also helps the process of *whakawhanaungatanga* or relationship building with participants. A strong relationship between researcher/participant in case-based research is important for gaining truthful and rich information from participants (Hodgetts & Stolte, 2012).

The group 1 interviews took place in a range of locations to suit individual preference. Interviews were held in people's current accommodation, the community mental health interview room, public libraries, and cafes. I supplied food to all participants to provide a culturally appropriate method of creating a sharing environment for Māori participants. I began by re-introducing myself to participants and re-explaining my role within the DHB, then verbally explaining the information sheet (Appendix B and D) and the consent form (Appendix I). A particular focus was given to explaining the process for maintaining anonymity for participants. Participants were given the opportunity to select a name that they

would like to be known as throughout the research. Any names mentioned in interviewing have been removed in the transcript and replaced with a pseudonym. Using pseudonyms allows participants to maintain their anonymity (Thomas & Hodges, 2010). The limits of anonymity were explained to participants, since those who are familiar with a participant's life story might still be able to identify them through the study. Consent forms were signed by participants and their consent was given for their interview to be recorded.

The initial interviews for group 1 generally took between one to two hours and focussed on people's experiences of trying to find accommodation, their history of homelessness, barriers to housing, wellbeing, and relationships with services. Participants received their koha at the conclusion of the initial interview. The date for a follow up interview was organised at the end of the initial interview. The researcher generally arranged this for two weeks after the initial interview, although this had to be flexible as often the participants would have a change of plans or needed to reschedule due to stress related to housing and mental illness. After each interview, I would spend time filling out the participant background sheet (Appendix G and H) and any areas missed or needing elaboration would be identified. Initial interviews were all recorded and transcribed verbatim straight after each interview.

The follow up interview with group 1 participants was generally between half an hour and an hour in length. The questions in the follow up interview focussed on areas identified in each participant's background sheet as being missing or needing elaboration from information provided at the initial interview. The follow up interview would begin with a summary of the initial interview then progress to specific questions from the previous interview. This follow up

interview also provided the opportunity for the participant to ask any questions or add any additional information that they had thought about since the initial interview. The follow up interview was generally more relaxed and less structured. Two of the follow up interviews were conducted in public places such as a café or public library. To maintain anonymity during the interviews that took place in public spaces, I avoided using a recording device but instead took notes. One of the participants declined to take part in the follow up interview because of stress related to their accommodation search, and their appointments with other services.

The group 2 participants were interviewed in their place of work at a time that suited them. The group 2 interviews were between one and two hours in length. I began by introducing myself and my role in the Waikato DHB and the current research project. Anonymity and its limitations were explained to the participants. The researcher gained consent from the participants for their information to be used in the study and for interviews to be recorded. The two participants both chose to have their roles identified. It was explained to participants clearly that this would increase the likelihood of their being identified.

The group 2 interviews focussed on the participants' experiences of supporting people experiencing homelessness, barriers to sustainable housing, possible solutions or support for people experiencing homelessness, and their career history. Group 2 did not have a follow up interview, but the participants were offered the opportunity to review their interview transcripts and to add additional information or edit the information they had given during the interview. Both participants declined the offer to do this.

Participants

In group 1, five participants who had mental illness and had experienced homelessness in the past two years were recruited. Their ages ranged from nineteen years of age to thirty-two years of age. Three of these participants were female, two of these females identified as New Zealand Māori and one identified as New Zealand European; the other two were males who identified as New Zealand Māori. At the time of the interviews, they were all clients of Waikato DHB Community Mental Health teams. The participants in group 2 were staff members from agencies that interacted with people (on a daily or weekly basis) who experience homelessness and mental illness. Both staff members have worked in their roles for extended periods of time. The next section offers a brief description of each of the participants.

Group 1 Participants

Beyoncé is a nineteen-year-old female of Aotearoa New Zealand Māori descent who was eighteen weeks pregnant at the time of the interview. Beyoncé had been in the care of the child protection service, Child, Youth and Family (CYFs)³, since she was ten years of age. This was also the age that Beyoncé had her first contact with mental health services. During the eight years that Beyoncé was in CYFs care she moved often between foster homes. The longest period that Beyoncé lived in one place was from the age of fifteen to seventeen when she was in a youth correctional facility. Other housing placements lasted less than a year. Before going into CYFs care, Beyoncé would move between her aunt and her

³ Child, Youth and Family (CYFs) is Aotearoa New Zealand's Child protective service. This agency works with children who are at risk of violence, neglect or criminal offending. During 2017 this service was renamed Oranga Tamariki: Ministry for Children.

mother's homes. At the time of the interview, Beyoncé was living in her sister's three-bedroom house with fourteen other people. She shared her bedroom with six of her nieces and nephews.

Sarah is a twenty-six-year-old female of European descent. Sarah's mother passed away when she was eleven years old. During her childhood Sarah had moved between her aunt and uncle's house, her grandparents' house, and her father's house in Auckland. Sarah's most stable period of housing was in her childhood when she lived in the same place from seven to eleven years of age. Sarah has had contact with mental health services sporadically since the age of seven. Sarah has had two children but neither of them is in her care. She moved to Hamilton from Wellington approximately a year before the interview. During her move Sarah experienced her most recent period of homelessness. At the time of the interview, Sarah was housed in a privately rented flat that she had maintained for a year.

Karen is a thirty-two-year-old female of Aotearoa New Zealand Māori descent. She has experienced housing insecurity since the age of seventeen years old and had been a 'streety' in Hamilton for many years before being housed in a NGO flat. This NGO specialises in housing people who have mental illness. Karen faced adversity in her childhood including experiencing abuse. She was then forced to leave home at the age of seventeen due to her family's lack of understanding about her mental health. Before this time, Karen's family had moved around, in part, due to her parents' relationship breakup. The relationship breakup resulted in Karen being moved between her parents' homes in the Waikato and Whangarei. At the time of the interview, Karen had been housed in a flat managed by a NGO for four months.

Andrew is a thirty-year-old male of Aotearoa New Zealand Māori descent. He has worked in hospitality and the trades in the past, but is not currently employed. However, Andrew had been volunteering with the Hamilton Homeless Trust and has also performed odd jobs for his mother's landlord in the months preceding the interview. Andrew had been released from prison approximately six months before the interview. Andrew has two children; one lives with their mother and the other is in CYFs care. At the time of the interview Andrew was couch surfing⁴ with friends.

Tane is a thirty-two-year-old male of Aotearoa New Zealand Māori descent. Tane grew up in the Waikato area with various whānau (family) members. Tane described a pattern of being moved from one whānau member's home to another when his behaviour, which he says is related to poor mental health, became too much for them. Tane has spent time on the streets in both Australia and Aotearoa New Zealand. His period of homelessness in Australia was related to whānau struggling with his transient living style. Tane recently was in prison on kidnapping charges related to a period of mental illness. Tane had his own accommodation but lost it when he went to prison. At the time of interview Tane was staying with his Nan (grandmother).

Group 2 Participants

Sue is a social worker with the Waikato DHB Assertive Community Treatment (ACT) team. Sue has worked with this team for approximately ten years. The ACT team has a caseload of approximately 100 clients who have

⁴ Couch surfing is a colloquial term that is used in Aotearoa New Zealand to describe moving often between friend or family member's houses, usually staying on the couch or sofa.

longstanding mental health diagnoses. Clients usually have experienced a high number of mental health hospital admissions, high levels of homelessness and criminal recidivism. As one of the social workers in the team, Sue often supports her clients to attend Work and Income New Zealand (WINZ) appointments and applications for housing.

Luke is the manager of the Hamilton Christian Men's Night shelter and the Hamilton Women's Night Shelter. Luke has managed the Hamilton Christian Men's Night Shelter for the past eight years, but has only started running the Hamilton Women's Night Shelter in the past year. He is from the United Kingdom (UK) where he was raised in a children's home. This led to personal experiences of homelessness as a young person. The Christian Hamilton Men's Night Shelter has twenty-six beds available for use. Luke reports that the majority of guests that stay would experience poor mental health or mental illness.

2.4 Ethical considerations

Participants recruited in group 1 of the research are part of a vulnerable population due to their experiences of mental illness and homelessness. I had to be very responsive and sensitive to the needs of the participants as it was very important that the research did not negatively impact on the person's mental health and wellbeing. I had to be extremely aware of the risk of adding extra pressure for people who might be struggling with their mental health. This meant that there had to be a level of flexibility about meetings and timeframes. With four of the five participants from group 1, meeting times were rearranged and rescheduled because the participants were struggling with poor mental health and living pressures. One of the participants declined to have further contact for the follow up interview due to struggling with poor mental health at the time. Information

about how to access additional supports was provided to participants who found some of the stories shared in interviews brought up distressing memories.

Throughout the interviewing stage, I was employed by the Waikato DHB and acted as a support worker within the Mental Health Crisis Team. I was open about my role within the Mental Health Crisis Team with the participants and made sure that during the interviewing stage, I was very careful to keep the interactions with participants separate from my DHB role. If my participants had interactions with the Mental Health Crisis Team during this time I would not be involved in their care. If I had become involved in the care of participants through the Mental Health Crisis Team this would have meant that I would have been privy to personal health information. Maintaining a distance within my role as a support worker for the DHB from participants during the interviewing period decreased the likelihood of an unequal power relationship being created by the position I held in the Mental Health Crisis Team.

As discussed in Chapter one, it was important that the methods and theoretical approaches used in the study were culturally appropriate for Māori participants. Four out of five participants from group 1 identified their ethnicity as New Zealand Māori. Because of inequities experienced by Māori in mental illness and homelessness, it was important to use research methods and theoretical frameworks that are culturally responsive to Māori. This was to ensure that equitable opportunities were given for Māori to express themselves and provide their views on how services help them to achieve sustainable housing and holistic wellbeing.

2.5 Process of analysis

The process of analysis started straight after interviews when I spent time taking notes on impressions of the interview, and topics of interest that emerged on the background sheet (Appendix G and H) as noted earlier. The recordings of interviews were then transcribed by me, verbatim, after each interview, which allowed me to become extremely familiar with the participants narratives for the analysis of information. While I was transcribing the interviews, I took notes of initial impressions of the information gathered; topics mentioned repeatedly, gaps in the information or areas that needed to be expanded on in future interviews. Any gaps identified were then applied to interviews with additional participants, adding extra questions to explore topics further, and improved phrasing to clarify questions. If an unexpected topic came up in an interview and it was deemed to be important to the research questions, then this would be added to the following interview. The first interview with each participant also dictated the areas covered in their follow up interview, so it was important to have a firm grasp of the information provided so that the researcher could decide on topics that needed to be further investigated in the second interview.

For the next stage of analysis, I re-read interview transcripts. Initially interview transcripts were coded into topics using a thematic method of analysis. Thematic maps were created to try and link all of the codes into themes and sub-themes. These thematic maps were then reviewed several times to try to refine the data themes (Braun & Clarke, 2006). The theming of information was used as a way of focussing on important parts of the interview and arranging the participant's accounts in a way so that I could focus on key statements and narratives that were discussed by the participants. The themes were used to create

a discussion around similarities and differences between the participants and current literature.

I then looked at the narratives constructed by the participants through their story telling of their lives and circumstances. Narrative analysis focusses on how people use and share language through the form of stories. Studying of narrative not only allows us to learn about the events within a participant's life but also the meaning that they attribute to these events (Boréus & Bergström, 2017).

Additionally, narrative analysis allows more room for personal agency while maintaining an awareness that our stories are always both personally and collectively shaped. With this in mind during the analysis process I focussed on the person's immediate environment or personal history, but also widened the lens to incorporate the economic and socio-political context that the person lives within. Including the wider context of a participant's life was important in this study about the social issue of homelessness due to the understanding that the researcher gains of the individual from learning about the wider context that has informed and helped to build their personal narratives (Hodgetts & Stolte, 2012). The connections between the participants' accounts and the wider societal context will be discussed in the following chapters.

Chapter Three: Analysis of homeless participants

This chapter explores and analyses the information gathered from five of the seven participants of this study. These five participants Beyoncé, Sarah, Karen, Andrew, and Tane were, at the time of the interviews, all clients of a community mental health team and had experienced at least one period of homelessness in the last two years.

In this chapter, I begin by reflecting on participants' life biographies, childhood adversities, and consider how these have impacted on their current life circumstances. Next, I analyse participants' understandings of their mental health, and their experiences of stigma and social exclusion. I then discuss how participants attempt to distance themselves from stigmatising social narratives about mental illness that circulate in media representations and wider public deliberations. This will be followed by a discussion of participants' experiences with agencies. I lastly look at the challenges participants faced sustaining social relationships.

3.1 Life biographies

In the interviews none of the participants were asked to provide a life biography. Questions were centred on life events such as their first period of homelessness. Despite the absence of a direct line of questioning, most of the participants provided details about their life history throughout the interview, providing the interviewer with lots of detail about their lives both before their experiences of homelessness, during their periods of homelessness, and when they had been housed. All of the participants providing biographic narratives through the interview process is significant as it shows how the participants were building

their personal narratives about themselves and their lives to include all of their experiences and not just their experiences of homelessness or mental illness. By articulating a biographical self-narrative, the participants are showing how they are more than the experiences of mental health and homelessness.

3.2 Childhood adversity

All of the homeless participants had some significant form of instability in their childhood, which often involved moving frequently. The female participants also experienced forms of abuse in their childhood, two of them having child protective services involved in their care. Such childhood adversities reflect the high rates of child abuse in Aotearoa New Zealand (Peters & Besley, 2014). For example, Beyoncé went into foster care at the age of ten. For the eight years that Beyoncé was in foster care, placements usually lasted less than twelve months at a time.

Interviewer: “OK, so you went through foster homes?”

Beyoncé: “Yeah. I just came home last year.”

Beyoncé’s succinct reply to the interviewer’s question above demonstrates that, throughout her childhood, her placements with multiple foster families did not feel like home. Although, Beyoncé was housed by these foster families and Oranga Tamariki (Aotearoa New Zealand child protection services), this did not mean the same as being provided with a stable home. Beyoncé “came home” when she moved to Hamilton to be with her biological family. This suggests that for Beyoncé part of home is having continuity and family members around her. The distinction between house and home is important, since home is a place that is defined by a person themselves and based on what they value (Isogai, 2016;

Tomlins Jahnke, 2002; Veness, 1993). Home implies an emotional connection to a place and a sense of belonging that can be missing in a person's housing. A home has additional benefits to health and wellbeing beyond just providing shelter (Isogai, 2016). Beyoncé's feelings of not being at home throughout her teenage years are both connected to poorer outcomes as an adult, poorer mental health, and increased chances of homelessness (Banyard, Hamby, & Grych, 2017; Curry, 2017; Duin et al., 2017; Turney & Wildeman, 2017). Foster care is usually a last resort when a family is in distress (Oranga Tamariki, 2012). Even in the best circumstances, being removed from one's family is a traumatic and stressful experience (Oranga Tamariki, 2012). More so, when one's family has a difficult history and there has been a breakdown in family relationships. While many foster parents are caring, there are some that fall short, or are unable to offer long-term stability for a child, unfortunately, the foster families Beyoncé was placed with were among this latter group.

The State's involvement in the removal of children from their families and placing them in foster care is usually a last resort (Oranga Tamariki, 2012). Aside from such actions by state agencies, there are also more informal situations where children can be removed from their parental home. For example, Tane spent most of his childhood living with his whānau (family), but when Tane 'misbehaved' he would be sent to an extended whānau member's house.

"Yeah, I just had a problem with constantly getting shipped around all the time. Because I used to play up or be naughty and then I'd always get sent to relatives. That's the sort of lifestyle I've always had since I was younger. Just always constantly moved around."

Through his discussion around his childhood Tane suggests a sense of inevitability about the disruptions in his childhood. Tane refers to being shipped around in the past tense; “had” suggests that this is in the past and no longer occurring. However, Tane still does not have a fixed abode spending most of his time lodging at his grandmother’s house. Tane draws his childhood experiences of being sent away by his parents when he ‘was naughty’ as an explanation for why he still lives a transient lifestyle where he will move between family members.

Often a child’s behaviour can be caused by a range of environmental factors including but not limited to instability, abuse, learning difficulties, parenting style, or feelings of powerlessness (Greene, 2016). Tane’s ‘naughty’ behaviour is not simply due to the individual deficits of Tane or his parents. It is important to also consider the situational context and a combination of instability, parenting styles, and feelings of powerlessness. At another point in the interview when Tane was asked about his first period of homelessness, he described a situation when he was fourteen and left home to stay at a friend’s house. When asked whether his Mum was worried Tane said that “my mum didn’t really care about us that way. I’ve just sort of learnt to fend for myself since I was young.” This pattern was very disruptive for Tane and reinforced a conditionality to his parents’ affections. Tane was only moved to extended family member’s homes when he ‘was naughty’. This reinforced the idea that his parents’ affection for him was dependent on his behaviour and Tane’s ability to conform to their ideal of how he should behave.

Tane did not speak in more detail about his parents so I do not know much about them, but I could extrapolate from his account that his parents may not have had many opportunities to develop coping or parenting skills. This could be linked

to the process of colonisation where Māori have often suffered from intergenerational poverty, precariousness, systemic racism, and a lack of resources caused primarily by the confiscation of ancestral land during colonisation; forced assimilation; and breakdown of whānau (family) connections (Tomlins Jahnke, 2002). All of the above can make it much harder for parents to flourish and provide a stable and consistent home environment, which in turn creates struggles for the next generation (Finegood, Raver, DeJoseph, & Blair, 2017).

Consequently, whānau and parenting issues should not be seen solely as individual deficits, since they reflect deficits that exist in our socio-political environment that have been perpetuated since the colonising of Aotearoa New Zealand. The effects of these societal deficits and impacts of colonialism can also be seen in poorer health and social outcomes for Māori (Zambas & Wright, 2016).

3.3 Mental health, stigma and social exclusion

Through the interviews, I tried not to focus on participants' mental illness; however, for all of the participants their experiences of mental illness are a large part of their everyday lives, so this featured prominently throughout their accounts. A particularly strong theme was the stigma and social exclusion that the participants encountered because of people's perceptions of mental illness. Mental illness is commonly associated with stigma, which is defined as "negative attitudes, beliefs, and actions toward those with mental illness, which frequently leads to negative experiences for people with lived experience of mental illness" (Firmin et al., 2017, p. 37). Stigma can occur at three levels, social, structural, and internalised, which all interact and are impacted on by each other (Livingston & Boyd, 2010). Stigma can be experienced in different ways, and two of the

participants have experienced social stigma in the form of rejection from family because of their mental illness.

For Karen, her first episode of mental illness was the catalyst for her first period of homelessness, as her family was not able to understand what was happening for her or help her in the way she needed. Being able to understand a person is the first step in being able to help them effectively. Without family support, Karen was essentially on her own:

“That’s kind of how I ended up on the streets because they were, with my mental health issues, they were kind of judgemental”

Karen speaks about the discrimination that she experienced from her family around her mental illness, which led to a period of homelessness. Discrimination is one of the greatest predictors of housing instability (Priester, Foster, & Shaw, 2017). Karen describes how this discrimination is reinforced through the perpetuation of negative narratives about mental illness.

“I was crying because my brother was picking on me and he always does. He seems to think he can hit me because of my mental health. I’m just a nobody to my family and that kind of thing. It’s just like they don’t value me because of my mental illness.”

Karen expresses how in the eyes of her family she is not valued because of her mental illness; this is a reflection of a wider social narrative where people with mental illnesses are not valued (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). The value that is afforded to Karen by her family is not created in isolation. Narratives around the value of a person never exist in isolation and are always socially constructed (Sools et al., 2015). Therefore, when we read here that

Karen's family values her less because of her mental illness we can assume that this is a reflection of the community or society that Karen has grown up in. This societal narrative has been created through narratives around mental illness where those who are ill are seen as having moral failings (Livingston & Boyd, 2010). Narratives where people are valued less because of an illness create unfair and unnecessary disadvantages for people, especially when people already lack material and social resources. For all people to be able to flourish and have a good quality of life, societal narratives need to shift away from this moral deficit view.

Social capital and family support can work as a buffer and promote wellness for people who experience mental illness (Cattell, 2001). As well as promoting health, social capital and positive social relationships can also decrease the likelihood of housing instability (Priester et al., 2017). In contrast, poor social relationships can have negative impacts on health, particularly when these relationships are impacted by stigma. In Karen's situation her family held stigma about mental illness which impacted on her relationship with them, her housing, and caused internalised stigma.

“... I'm learning to um cope with the voices but I'm also learning more about you know cause I have, my therapist said I've actually got such a low self-esteem. So, she's helping me to build self-esteem, by um 'Karen you've achieved so much' and people telling me you know all my life I've been told I'm actually quite a lovely girl and I didn't see it. I always saw this agro person and always agro at everyone. You know, but it was because I just wasn't happy with myself I suppose.”

Karen's experiences of low self-esteem could be linked to internalised stigma caused by dominant social narratives about mental illness. The social narratives, which Karen has encountered at a young age through her family, have undermined her sense of self and identity. Internalised stigma has been shown to have negative impacts on recovery for people who experience mental illness (Firmin et al., 2017). These negative social narratives around mental illness could be creating a cycle where people are told horrible things about themselves, this impacts on their recovery and feelings of self-worth, which then makes them unable to meet neoliberal orientated expectations that people should be self-reliant. Neoliberalism, as was discussed in more detail in the introduction chapter, is based on individualistic principles and values autonomy and self-reliance over dependence and vulnerability. Consequently, people with mental illness can experience negative social narratives due to their reliance on services and their vulnerability (Berghs, 2014; Sherry, 2014). Unfortunately, the negative narratives, framed by neoliberal thought, can function as obstacles if people begin to believe them about themselves or others who experience mental illness. Negative social narratives about people with mental illness can reduce self-esteem and social connections, which can worsen experiences of mental illness and prevent people from achieving health (Schmitt & Branscombe, 2002). To achieve health, people facing mental health challenges need to develop alternative narratives or develop resistance to the stigma that exists in society today.

It is important to change social narratives through challenging the legitimacy of them; however, because of the pervasiveness of these ideas this is often a slow change process. In the meantime, people who live with mental illness need support to buffer themselves against the negative impacts of stigma (Firmin

et al., 2017). The quote above does demonstrate that Karen is developing stigma resistance and building an alternate narrative with the help of her therapist. In this case, Karen has had the support to imagine and enact an alternative self to the “agro person”. Stigma resistance is linked to increased self-efficacy, hope, improved outcomes, and quality of life (Firmin et al., 2017). More recently Karen has managed to secure accommodation, start part-time work, and maintain her health, which demonstrates the importance of being heard and supported rather than feeling judged and stigmatised. Karen’s self-worth has increased as she improves her quality of life, but also her social standing by fitting in with wider societal norms. The dominant social narrative portrays those that do not have housing or have mental illness as morally lacking. When people engage in activities, such as finding accommodation, that are portrayed as ‘right’, then people develop a greater sense of worth (Farrugia, Smyth, & Harrison, 2016). Because Karen has recently managed to secure accommodation, maintain her health, and start part-time work this growing sense of self-worth also reflects social narratives about what makes a person worthy or successful.

While Karen is growing stigma resistance Tane is also trying to challenge the narratives about mental illness that he learnt at a young age. Through Tane’s narratives about himself he discussed how his own narrative about mental illness and what this meant was developed through the narratives of his family. The negative narratives that he learnt about mental illness affected his sense of self when he developed mental illness.

“Because how I thought of it is like, when I was a kid I used to grow up and I used to know people with mental health issues and my family used to laugh about them. Nah nah nah just be bad about them. And then when I

ended up suffering from it I thought all the bad things were like a demon sort of thing, like a part of my illness, but I used to think that all people used to think that about me. Like think that ‘you’re nothing but a... you shouldn’t be on this... do the world a favour and kill yourself’ sort of shit. And that’s what I used to think people thought.”

Tane was raised with the social narrative that people who had mental health issues are worthless. When Tane himself discovered he suffered from mental illness, this social narrative directed his feelings about himself and what others thought of him. Tane is not alone in these feelings; social and dominant cultural narratives have oppressed and disempowered people with mental illness all over the world (Rappaport, 2000). This should not be the case, and dominant cultural narratives should be challenged when they oppress and disempower people to the point where they feel unworthy of life. Alternative narratives need to be created, so that people who experience mental illness can feel included and supported. An example of an organisation that challenges dominant narratives around mental illness is called GROW. GROW is a community of people who have personally experienced mental illness and who use this group to create their own community narrative about mental illness, this gives people power over the narrative (Lydia, 2014; Rappaport, 2000).

Andrew struggled with constructing his personal narrative about his experiences of mental illness due to forced application of the western medical model by his mental health treating team. Andrew understood his experiences of voices as his grandmother speaking to him and giving him advice when he was struggling. When these experiences were interpreted by Andrew’s psychiatrist as

psychosis, he struggled to try and explain his experience of the voices. Andrew was confused by the psychiatrist's diagnosis, so asked his mother for advice:

“I asked her how I explain, how do I explain myself in an assessment to say I'm not hearing anything that's not there, it's obviously in my memory and I think it's a good thing that I recall it but why when I'm in the depth of depression do I recall that? Is it like a, I don't know, an um a yearning to have that person in my ear, am I missing my grandmother yeah of course. But it took a while for them to lift that away from the diagnosis.”

Andrew heard his grandmother speaking to him and giving him advice when he was feeling depressed. Andrew's personal narrative about this was that it was a comforting experience and that having his grandmother offer support and guidance was a positive experience. He then struggled to explain this to his doctor who quickly added “psychosis” to his mental health diagnoses. The added label of psychosis was a struggle for Andrew and he felt that the doctor had misunderstood the context of his experience. Andrew's experiences with the mental health system applying the western psychiatric lens to his personal experiences of what happened to him influences his understanding of this event. Furthermore, it has meant that his experience that he initially felt was positive and had understood through a Māori culture, where there is a concept of Matakite or Māori giftedness where people may have a close connection to ancestors, now holds negative connotations for him (Taitimu, Read, & McIntosh, 2018). The reshaping of narratives about personal experience through a western psychiatric lens prevents people from finding their own understanding about their experience. For Māori it is understood that protective visions or voices can be a form of resilience (Taitimu et al., 2018). The western medical model can pathologise this,

and only see it as a symptom of illness. Both medical and the cultural understandings of the experiences of people like Andrew are essential in helping people achieve wellness, as defined by themselves and their culture (Taitimu et al., 2018).

3.4 Distancing the self from social narratives about mental illness

Social narratives can be created or reinforced through myths and misconceptions about mental illness, which are circulated in media, public deliberations and in wider social narratives (Claire, Raymond, John, & Aroha, 1999). These misconceptions impact people who experience mental illnesses, how they view themselves, and how others view them. Tane speaks about how media representations impact him.

“like I can laugh about my mental health now but I couldn't before like you know just the word of it being, the stereotype for it used to make me feel thing. Because even when I watched programmes and things like that and they show a mental health patient on there and they show them that they're crazy and people are scared of them. And then I think to myself, do people get a real perspective of if that's how we are? Even that movie 'The Dark Horse' and things like that. And I've done things like that, try to, not as intense, but I've done things in front of crowds like that.”

Tane makes reference to 'The Dark Horse' which is an Aotearoa New Zealand film that is based on the true life of Genesis, a national chess champion who experiences mental illness. Genesis volunteers to help with underprivileged children at an afterschool programme in Gisborne, Aotearoa New Zealand. Genesis is rejected by his family and community, and is frequently told that he

will not be able to maintain his wellness. Genesis is able to maintain his wellness and rise above the poverty and gang culture to help the children develop a sense of achievement and value. Tane discusses a scene at the beginning of the movie where Genesis is shown very unwell, being taken to hospital forcibly by mental health services. Although Tane states that he has done similar things, seeing this in a movie was hurtful for Tane. This scene held up a mirror to current practises in mental health services. In the movie, Genesis is forced into hospital and then discharged with confusing discharge planning, to an unstable housing environment, and given very little support. The comments made by Tane about this movie and his reflection on the accuracy of what is shown could suggest that Tane may have experienced similar circumstances in the past and can relate to Genesis.

Tane then goes on to discuss the hurt feelings that he experiences from other popular culture references and representations of mental illness. Mental illness is predominantly featured in media sources like movies or television shows with people who are deviant or criminals (Claire et al., 1999; Rappaport, 2000). Most mainstream media sources do not focus on recovery or on people who live full and productive lives with mental illness (Nairn & Coverdale, 2005). The tendency to associate mental illness with deviancy or danger has contributed to a narrative where people with mental illness are socially constructed as less than or part of an out group (Schneider, 2010). Similarly, people experiencing homelessness are also often viewed as an out group, which increases their social exclusion (Watson, Crawley, & Kane, 2016).

In an attempt to minimise these feelings Tane verbalises that he finds his mental illness humorous. This appears to be Tane's way of distancing himself

from negative feelings about mental illness. On an individual level, humour can be used as a way of coping with stress in a person's life. It can help to decrease the impacts of stress and help to protect a person's self-concept (Martin, Kuiper, Olinger, & Dance, 1993). Self-concept is made up of two parts, the actual and the ideal, people who have large discrepancies between these two parts often struggle with low self-esteem, depression, and stress (Martin et al., 1993). Tane's use of humour softens the discrepancy between actual and ideal self-concept and helps him restore a positive sense of self.

The negative social narratives that exist about mental illness mean that often people are embarrassed about their diagnoses and feel excluded from what is considered a 'normal' state of being (Sercu & Bracke, 2016). Beyoncé discussed the implications of this:

“Because I think I... I actually stop taking them [medications] because I think that I'm normal again. So, I stop it and then like within a week or so then I'm like all over the place.”

Beyoncé's resistance to taking medications can be related to the negative social narratives about mental illness. Beyoncé's story about her resistance to taking medications is related to Tane's earlier story where he is so affected by the negative narratives about mental illness that he considered himself unworthy or life. Similarly, Beyoncé's resistance to taking medication is directly related to stigma and negative narratives about mental illness. By not taking her medications Beyoncé seeks to distance herself from a practice that would identify her as having a mental illness. By doing this Beyoncé becomes unwell again. Beyoncé's life and wellness are directly impacted by the negative narratives around mental

illness. Beyoncé's narrative here also reflects that there is a dominant social narrative around what "normal" is. Those who have to take medication for mental illness are excluded from this socially constructed idea of who is "normal". This socially constructed state of being 'normal' excludes those who have mental illness and forces those with mental illness to inhabit the space of the out-group or others.

3.5 Interactions with agencies

The participants in this study all interact frequently with a range of support services who provide income and housing assistance. These support services were not always helpful for the participants, and often employ approaches that are punitive and reflect an unequal distribution of power. This finding is reflective of the findings in a study by Hodgetts, Chamberlain, Groot, and Tankel (2014) where they found similarities between the current practises of Work and Income New Zealand and characteristics of Intimate Partner Violence (IPM), such findings are not isolated, as other Aotearoa New Zealand studies have also found support services tend to adopt punitive practises, and can make it difficult for service users to access all of their entitlements. As Gordon (2017) identifies, service users now frequently need the support of an advocate who has knowledge of entitlements to be able to access full support. Andrew discovered that to gain the services he needed it was beneficial to have an advocate, in the form of his Community Mental Health Keyworker attend appointments with him:

“And I asked my KW [Keyworker] to come in with me because there is some anxiety there when it comes to dealing with Work and Income [Aotearoa New Zealand Welfare agency] and I tried to express that I would much rather my KW be there. They're like 'well why don't you call

him now and get him to come here' and I'm like 'I can't, I have to do this myself'. I've had two applications with housing. I'm at the last bits of the second application. The first application I tried my best for them to like hold back so I could have KW there but they wouldn't. Um so fingers crossed and stuff like that for this application."

In the quote, Andrew has mixed emotions about needing support from his keyworker with applications for Work and Income. Although Andrew would prefer to "do this myself", he is fully aware that it can be more difficult to get the help he needs without an advocate. Andrew is trying to maintain his sense of worth and self-efficacy through trying to access Work and Income and Housing New Zealand without support. It has been found that often people have better experiences at Work and Income when they are supported by an advocate (Gordon, 2017). However, the use of an advocate is not always possible or desirable for the person attending appointments. In recent years Work and Income have introduced new processes including the use of security guards, creating a hostile and unapproachable environment (Herselman, 2015). Related punitive approaches in Work and Income agencies mean that often clients miss out on entitlements if they do not have advocates alongside them that know the system and are able to help clients apply for the right resources. It is unfortunate that a welfare agency that exists to support people is not accessible to vulnerable people like Andrew without the use of an advocate to support their application. The need for advocacy reflects the low status and relative powerlessness afforded to beneficiaries which probably doesn't give one the legitimacy needed to bargain and argue with a case manager. In Andrew's case he missed out on housing whilst being homeless due to not having an advocate attend his appointment with him.

Andrew's experience, where his application was declined for social housing whilst being homeless, was echoed by Karen. When she was declined for social housing Karen was so hurt that she gave up on the process.

"I remember, when I was on the streets I tried to get a house from Housing New Zealand [Government social housing organisation] and they wouldn't give me one, and I was on the streets. Walking up the side of this road and they're ringing me, Housing New Zealand is ringing me saying 'look we can't house you, we can't help you' and I'm like 'well fine' and then I'm hanging up the phone. What's the point, you know? Back to the drugs, back to the drugs scene, back to the alcohol. They don't want to help me. It was actually quite hurtful."

Housing New Zealand declined Karen's application for housing while she was living on the streets. This illustrates the failing of the current housing system in Aotearoa New Zealand. As a result, her rejection contributed to Karen feeling hopeless and defeated. In her quote you can sense her disappointment and frustration with a housing system that does not help when you are literally living on the street. At the beginning of the quote, Karen repeats that she was living on the streets at the time that this event happened. The repetition of this statement emphasises the significance of her circumstance, but it also reflects the incredulousness felt by Karen that Housing New Zealand could decline her application whilst her circumstances were so dire.

Andrew also described other processes at Work and Income as challenging and felt like he often missed out on resources due to the system's requirements.

“It’s not very inviting. Having to talk in reception while there’s like 10 people in line, requesting a room or requesting ‘can I talk to someone [privately]’ ‘no, you have to tell me now’ ‘no I’d rather not’. Rather than talk to them about my situation I’d just say ‘ok it’s ok’ and leave and come and see my community mental health team keyworker and he’ll say ‘you should’ve told them’ and I’ll be like ‘no there were like 10 people in line, I only want one person to know not the whole of Hamilton’.”

Maintaining an impression with people that there is nothing wrong is important to Andrew. In the quote above, Andrew discussed how Work and Income expected him to share his story and effectively shame himself to get assistance. The open layout of most Work and Income offices forces people who are requesting emergency appointments to share their reasoning while being in line with other people. This situation, as described by Andrew, is dehumanising and reflects the current punitive approach to social welfare systems (Gordon, 2017; Morton, Gray, Heins, & Carswell, 2014). Furthermore, there is an imbalance of power in this situation; a person is expected to embarrass themselves in front of other people in order to access money for food or shelter. In an Aotearoa New Zealand study by Hodgetts, Hodgetts, Chamberlain, et al. (2014), power relationships between Work and Income and the people they support show characteristics of intimate partner violence (IPV). For example, humiliation is a form of psychological abuse that is linked to IPV. This links to the situation described by Andrew where he explains that in order to gain assistance he was asked to humiliate himself (Krug, Mercy, Dahlberg, & Zwi, 2002). Victims of this approach, like Andrew, are stripped of dignity in their attempts to gain the necessary resources for survival (Krug et al., 2002). Controlling approaches to welfare have been enabled by

narratives constructed in Aotearoa New Zealand's neoliberal orientated society. Neoliberalism demands self-reliance. The use of welfare support is viewed as arising out of a lack of self-reliance and is further constructed as evidence of a lack of morality (Hodgetts, Chamberlain, et al., 2014). The construction of this narrative allows the development of a punitive welfare system that restricts the access to resources depending on whether a person is deemed worthy (Hodgetts, Chamberlain, et al., 2014; Morton et al., 2014).

All of the participants were on a benefit; and two of the participants also maintained part time jobs. The benefit rate within Aotearoa New Zealand has not risen at the same rate as housing costs. Because of the low benefit rates all of the participants were concerned about the rising price of rental housing and how that affects their financial status. Juggling living costs and debt is a constant issue for many people who live with low incomes and can impact on people's ability to access housing in the future because of their poor credit scores (Cattell, 2001; Veness, 1993). This creates a poverty trap that many people are unable to get out of, impacting on their health, wellbeing, and social relationships (Burns, 2015; Lawson, 2012; Parsell & Marston, 2012). The majority of participants had poor tenancy histories and one of the participants did not have a tenancy history. This acted as a barrier for them when they were attempting to find a rental in the competitive rental market. Poor tenancy histories were in some cases linked to a period of illness. Tane got "black listed" after his brother used his flat for parties while Tane was in prison after a crime that he connects with a period of illness. Tane's brother then held parties in his house and all of his belongings were stolen. Although all of these factors limit Tane's accommodation options, Tane also feels

like his options are limited by stigma and lack of understanding about mental illness:

“And I’m just stuck, stuck on where to go. Because it’s like, I go to appointments at like People’s Project [Housing First Agency] and I feel as though they can’t help me with my situation because I need support networks and things in place. They don’t understand me if you know what I mean. They’re not in a mental health sort of thing so I feel like I can’t fully open up to them because they’re not a mental health place and I feel uncomfortable sharing my... what I suffer from to them.”

Tane’s rental history acts as a significant barrier for finding accommodation. But in the quote above, Tane explains that he also experiences additional barriers to accommodation in the form of stigma and lack of understanding about mental illness. Tane does not feel comfortable disclosing information about his mental health to people who are not familiar with mental illness, possibly because of his family’s beliefs about mental illness, which were discussed in the ‘Mental health, stigma and social exclusion’ section. Tane would feel more comfortable accessing housing through a service that has staff that understand his mental health and are able to “understand” him and his needs. Deinstitutionalisation (as discussed in the Introduction chapter) aimed to integrate people who experience mental illness into the community (Brunton, 2003). The challenges faced by Tane reflect that true social integration into the community has yet to be achieved.

3.6 Social relationships

The importance of social relationships was evident in all of the participants’ narratives about their lives. Their stories were filled with their connections to

people and how these relationships have impacted on their decisions and life path. For Tane, his social connections with his father's family were impacted by his mental illness because of the cultural expectation that as the oldest grandson he should fulfil a role within the family:

“It’s because in my family I’m the first grandson on both sides of the family. And I’m supposed to be something. And that’s the reason why my Dad’s family won’t have nothing to do with me because I’m supposed to be the leader of the family sort of thing. I’m the oldest grandson on both sides and I think that’s what’s wrong with my Dad’s family is because... and a lot of people. That I’m not living up to my name sort of thing. That I’m not actually doing the right things. Because I’m supposed to get my photo, my face ta moko’ed⁵ I’m that kid.”

Tane’s narrative of how he’s “supposed to be something”, suggests that he feels like he has not succeeded. Earlier in the chapter we discussed how Tane’s family held negative beliefs about people with mental illness and this in turn shaped Tane’s personal narrative about himself and his worth when he started experiencing mental illness. The quote above expands on this and shows how Tane feels that he is not living up to the expectations of his extended family because of his mental health diagnoses. Tane’s family may not think he is able to live up to whānau expectations due to their negative beliefs about mental illness. However, there is no reason why a person who experiences mental illness may not act as the head of a family. As was discussed above with Andrew’s experiences, historically people from the Māori culture who experienced similar phenomenon

⁵ The puhoro is a traditional Māori tattoo on the legs and posterior and the ta moko is a traditional Māori facial tattoo (Te Awekotuku & Nunes, 2007).

to schizophrenia (auditory and visual hallucinations) may have been seen as having special abilities or Matakite and a closer connection to ancestors (Taitimu et al., 2018). In Tane's case, his family does not view his mental illness as a positive and discriminates against him because of his diagnoses.

In Tane's quote above he describes how he is rejected by his family because they do not value him due to discrimination about mental illness. This lack of value is demonstrated when Tane was not given a puhoro or ta moko. The puhoro is a traditional Māori tattoo on the legs and posterior and the ta moko is a traditional Māori facial tattoo. Both the puhoro and ta moko signify mana (status, power or prestige) (Te Awekotuku & Nunes, 2007). Traditionally, the designs of such tattoos have been used as a display of a person's status within an Iwi (tribe). Tane feels like he is not worthy of these symbols of status because he is "not living up to his name". This negative perception of himself has been reinforced by his family. Furthermore, both Tane and his family appear to construct his worthiness based on his housing status and mental illness. Accordingly, this construction of worthiness implies individualised blame. However, both of these circumstances are out of Tane's control, yet, the predominance of individualised blame in Tane's account reflects wider social narratives around both mental illness and homelessness and the neoliberal principle of self-responsibility.

The tendency for mainstream views of homelessness to be viewed as a personal failing reduces collective responsibility for poverty as a social issue (Burns, 2015; Hodgetts, Chamberlain, et al., 2014; Jeppesen, 2009; Lawson, 2012). Similarly, those with mental illness are blamed often for their health situation and portrayed as deviant or drug addicts (Burns, 2015; Claire et al., 1999; Schneider, 2010; Turney & Wildeman, 2017). When a person experiences

the combination of both mental illness and homelessness they become one of the most socially excluded and marginalised groups within society (Amore & Howden-Chapman, 2012). This social exclusion and marginalisation is reflected in Tane's quote above, where his family has withdrawn his social standing within the family because of mental illness and homelessness. Tane's connection with his family has been impacted by discrimination about homelessness and mental illness. Similarly, the other participants also experienced diminished connections with their family due to the transience of homelessness.

Three of the participants have children that they have diminished connections to and do not have regular contact with. For Karen the loss of contact with her son was directly related to her homelessness:

“But I lost contact with them because I ended up on the streets. I had no phone. Um no information. Like no phone number. So, I lost contact with him for about 2/3 years. And then I found his name...I got help with his name well with his information through a mental health worker and she found the address and the phone number and I was like ‘Yes that’s them’ so we rang them and we explained to the [foster] mother I was kind of all of the where. I wasn’t really stable, I finally got myself a house now, I’ve finally got somewhere to live. And she was like ‘OK that’s cool’. And about two weeks later she rings me ‘we’re coming to Hamilton; can we pop in?’ and I was like ‘Yeah’ and that’s when I bought those biscuits.”

At the beginning of this narrative Karen discusses the breakdown of the relationship as being her entry into homelessness. Further through her account Karen discusses not being stable in the past sense and uses the word “finally” to

describe getting a house and having somewhere to live. This statement from Karen indicates how she views being housed as a turning point in her life. Establishing housing stability allowed Karen to reach out and contact her child and gave her hope for creating a relationship with him. This reinforces the importance of housing for the creation and maintenance of relationships.

3.7 Summary

The participants featured in this chapter were, at the time of this research, being treated by a community mental health team and had experienced homelessness at least once during the last two years. Although there were differences in backgrounds of participants, all of the participants had experienced significant childhood adversities, which has been linked to increased chances of developing mental illness and increased chances of housing insecurity (Banyard et al., 2017; Curry, 2017). Participants' narratives were filled with descriptions of their experiences of stigma and social exclusion due to the stigmatising social narratives about homelessness and mental illness. The social narratives that are created in neoliberal orientated societies system fail people who experience mental illness or homelessness and disempower people. Neoliberal principles of self-reliance have also allowed for the development of punitive social welfare approaches, limiting participants' options by as discussed by Andrew and Karen.

Chapter Four: Analysis of staff participants

This chapter will focus on the analysis of two participants Sue and Luke. These two participants both have many years' experience working in careers where they interact on a near daily basis with people who experience homelessness. Sue works within an Assertive Community Treatment Team for mental health services and Luke manages a Men's and a Woman's night shelter. Throughout their interviews, Sue and Luke showed empathy towards the group of people this study focusses on, those who experience mental illness and homelessness, and seem frustrated when services and society create barriers for them. This chapter will begin with a reflection on deinstitutionalisation and institutions. I will then explore Sue's narrative about the societal imbalances encountered by people experiencing homelessness and mental illness. The chapter will then move on to discussions about how the social determinants of health impact on the lives of Sue's clients. Lastly, I will explore the solutions for homelessness that are discussed by Luke and Sue.

4.1 Institutionalisation

In the past, institutions were commonly used as a treatment facilities for people who experienced mental illness in Aotearoa New Zealand. Tokanui was the mental health institution for the Waikato district, where this study took place. It was opened in 1912 and closed in 1997 (Swarbrick, 2015). The process of deinstitutionalisation of mental health services, that occurred globally and in Aotearoa New Zealand, led to the closure of mental health institutions such as Tokanui in 1990s (Brunton, 2003). This change was based on the principles of including people within the community, and increasing people's choice and

control (Brunton, 2003). However, the disestablishment of institutions did not instantly improve conditions for all people. In some cases, poor planning put pressure on community resources and contributed to increased precariousness for people with mental health conditions (Dear & Wolch, 2014; Novella, 2010). Luke discusses the tensions created by deinstitutionalisation:

“I’m not going back to the institution kind of thing. But, it’s hard to understand how it’s working now, because it’s not. The community care type model where you have houses in the community and are meant to do like everybody else is not working and I see that here.”

Luke’s quote shows a tension between the interventions for housing the vulnerable population of people who experience mental illness. In his position as a manager in a men’s night shelter, Luke comes into regular contact with people who do not receive adequate mental health care. But, he also acknowledges that going back to mental health care through institutions is also not a great option. In particular, Luke feels this tension in his role as he is privy to stories from his guests where the community care model is not functioning well or meeting their needs. Luke observes that the current community care model is failing vulnerable people, which has prompted him to question the success of deinstitutionalisation. The key aims of deinstitutionalisation were to create community inclusion and increased choice for people who experience mental illness, but in some localities there was poor planning and insufficient resources invested in the transition into community living (Brunton, 2003; Dear & Wolch, 2014). For example, the poor planning of deinstitutionalisation in Australia was shown to increase pressure on services like shelters or boarding houses (Drake, 2014). It is likely that this is

similar in Aotearoa New Zealand, and that the pressure on shelters that Luke experiences is not just localised to Hamilton.

The move towards the community care model through deinstitutionalisation was undertaken to improve quality of life for people with mental illness, but it also enabled governments to disinvest in ‘bricks and mortar’ mental health services (Novella, 2010). Luke’s suggestion that community care models are not working could be related to this disinvestment in services. Institutions were expensive to maintain with all of the buildings and staff needed to keep them running efficiently. The move to community care enabled governments to disinvest in services, as they were no longer required to provide housing and staffing numbers could be decreased (Drake, 2014). Although the deinstitutionalisation movement was largely based on humanistic ideals, namely inclusion and choice, the disinvestment of mental health services and lack of investment and planning in community services has continued to negatively impact populations who experience mental health issues and disabilities (Berghs, 2014).

Luke describes in his quote above that services designed for community care often do not work for people who experience mental illness. Luke is describing a system that does not plan services to fit the needs of the people who the services are intended to benefit. The frustration that Luke feels watching people who are failed by the system is clear in his narrative, and there is almost a sense of desperation for the system to work more effectively for people in need. Whilst the design of services is often to blame for gaps in the system, social narratives have existed in the past that suggest the people who have fallen through the gaps in the system as doing so because of personal deficits (Buck et al., 2004;

Widdowfield, 2001). As was described in the introduction chapter, mental illness is listed as a form of disability (Statistics New Zealand, 2014). Within the disability sector, social narratives about personal deficits being the cause of people falling through gaps in the system has begun to be challenged (Berghs, 2014). Instead, the disability community are trying to shift the narrative to reflect that disability is a socially created conditions caused by social and political environments that disable people (Berghs, 2014). This alternate narrative emerging in disability literature challenges the long-accepted idea that people who experience disabilities have personal deficits, and acknowledges the role that the social and political world has on person's ability to live a full life. It could also mean that people are no longer seen as having a disability. Changing the narrative about disability should help to address some of the frustration that Luke experiences, when seeing the system fail people who experience disabilities, as it will begin to change the way we design services.

Designing services that do not disable people requires extensive consultation with people who have lived experiences of disability (Berghs, 2014; Bessant & Maher, 2009). Therefore, extensive consultation with people with lived experience of disability should inform the development of services and policy for the population it aims to serve. To achieve better service design, there is a growing movement where people are involved in a process of Experience Based Design (EBD) or co-design with communities to redesign health services (Bessant & Maher, 2009). The use of this design approach by public services has grown momentum because the inclusion of service users allows for a different perspective and fosters creative solutions to gaps within services. More participatory approaches could lead to more appropriate and effective services,

which would help to reduce the social exclusion and inequities that are experienced by people with disabilities. Inversely, poorly designed services can exacerbate social exclusion, inequities, and they can also institutionalise people (Baillargeon, Hoge, & Penn, 2010; Bessant & Maher, 2009). Since the demise of mental health institutions, people are still being institutionalised in other ways (Baillargeon et al., 2010).

Although mental health institutions are no longer as prevalent, other institutions, such as the prison system, still exist and continue to institutionalise populations. The prison population is relevant for this study, given that prison inmates have higher rates of mental illness than the general population and are also more likely to experience homelessness when released from prison (Baillargeon et al., 2010). In the past, people who experience mental illnesses in prison have had their mental illnesses poorly treated and have struggled to engage in mental health services once released (Baillargeon et al., 2010). The combination of poorly treated mental illnesses and recent release from prison puts people at some of the greatest risks of homelessness. Support for people who are newly released from prison and who experience mental illness is a large determinant of recidivism as well as homelessness (Denton, Foster, & Bland, 2017). High rates of recidivism and homelessness could be related to the former prisoners struggling to fit back into a domiciled existence. This is demonstrated when Luke says:

“I’ve got one guy, he’s been in prison for 8 years, he’s 65 years old and he loves the institution of it here. He’s been institutionalised and he loves the institution of here [the Men’s Shelter].”

This same gentleman changed the layout of the men's night shelter to reflect the layout of the prison. He has spent so much time living in institutions he struggles to adapt to life outside and tries to shape new environments to match the institution he is used to. Luke's quote suggests that this gentleman does not want to move on from the Men's Night Shelter even though this facility is only intended as emergency housing and a temporary option to keep men from sleeping rough (Mackie, Johnsen, & Wood, 2017). The reliance on shelters emphasises a failing of the system to not rehabilitate people back into society with enough support to create a life outside of institutions (Baillargeon et al., 2010). The gentlemen in the quote has moved from a prison institution to a hostel or shelter institution. Although shelters and hostels are not as restrictive as prison or hospitals they fit within the definition of an institution as they are an organisation founded for a social purpose ("Institution," 2018). Through the poor transfer of this gentleman from prison to the shelter he has been transinstitutionalised (Drake, 2014). Increased support for people who are released from prison may help to improve their outcomes, as poor support for released prisoners has been linked to increased rates of recidivism, homelessness, and negative health outcomes (Baillargeon et al., 2010).

In a more general sense, Luke's quote above suggests the environment provided by this night shelter is preferred by some guests and consequently they stay longer. Luke prides himself on taking the time to add small touches of kindness to his night shelter, through being aware of people's birthdays and by assisting with additional support when this is needed. Luke also maintains contact with people who move on from the men's shelter. In an example given during the interview, Luke spoke about a previous guest who was offered a job as a

volunteer after the guest was housed so he was able to maintain his social connections at the shelter. The Hamilton night shelter can provide positive social connections and a sense of belonging. Even though some guests have very positive experiences with the shelter environment two of group 1's participants discussed choosing to sleep rough rather than sleep in the shelter. In international reviews of shelters and hostels, it was also found that some groups of people will choose to sleep rough rather than sleeping in a shelter due to drug use being prohibited and lack of privacy (Mackie et al., 2017). The differences that exist within groups of people who may or may not be suited to shelter living reinforces the need for multiple approaches to emergency housing to allow people to choose services and settings that suit them.

4.2 Societal imbalances

While mental illness can affect all groups and classes in society, poorer people have far fewer resources and opportunities to draw on to help them cope with their illness and daily survival (Topor et al., 2014). In addition to coping with the symptoms and stresses of their mental illness, poorer people also face greater financial risks (Topor et al., 2014). These pressures can generate a downward spiral, which is much harder to recover from. Homelessness is therefore a greater risk for poorer people with mental illnesses. Their housing options are limited further by being required to provide additional information to landlords about their health conditions. Because of the power a landlord holds, where they have control over a necessary resource, there becomes a power imbalance. Sue speaks about power imbalances in her interview:

“... it [mental illness] continues to side line and marginalise them. I'm not asked if I have diabetes. I'm not asked if I'm short sighted. I'm not asked if

I'm overweight. I'm not asked if I get anxiety attacks. But it seems to be required information of my people [people who experience chronic mental illness].”

Sue works as a social worker within an acute mental health team who mainly works with people who experience chronic mental illness with high frequency of admissions to a mental health facility and high rates of transiency and homelessness. Sue has worked in this team for ten years and has an affinity with and empathy for the people that she works with (her clients). She repeatedly refers to them as ‘my people’. Part of Sue’s role is to support her clients to find accommodation. While Sue is trying to find accommodation for her clients, Sue is often asked about her clients’ mental health by the landlord or property manager. Sue highlights in her quote above how different expectations exist within society, people are not asked about their physical health conditions when attempting to find accommodation, but people will be asked about mental illnesses. Sue’s quote reflects how her clients are marginalised and have reduced choices because of the stigma that still exists within society around mental illness. The marginalisation of people with mental illness further increases their risk of homelessness (Amore & Howden-Chapman, 2012). In a competitive housing market, landlords are more likely to be very selective about who they choose as a tenant for their accommodation. This disadvantages those who do not fit into the perceived view of “normal”. In the past, people who experience mental illness or are perceived as being outside the category of “normal” have had some protection from homelessness in the form of state housing. However, since 2015 there has been a dramatic reduction in social housing stock alongside rapid population growth (Housing New Zealand, 2015, 2017). The current scarcity of social housing means

vulnerable populations often missing out on accommodation through these avenues too. Seeking assistance from other agencies, such as Work and Income (the Aotearoa New Zealand social welfare agency) can also provide challenges. Sue reflects on how difficult it is for her clients to approach agencies when they feel marginalised and undervalued:

“Where do you fit into society? Obviously, you have no worth. Therefore, if I have no worth in this situation how can I expect to stand up for my rights here. How can I go down to Work and Income and say I need money, I need a food grant, I need whatever without somebody coming beside me to support me? Because I have no worth.”

Sue’s clients’ personal histories and experiences with authority have reinforced their perceptions that they have no value. Their personal narratives about themselves have been shaped by their interactions with other people and wider social narratives about who they are. Sue’s clients all experience mental illness. Sue’s quote above suggests that her clients may feel a diminished sense of self. For these clients, this diminished sense of self could be related to dominant social narratives that exist about people with mental illness, as discussed in chapter three. Many people who experience mental illness struggle with low self-worth and diminished sense of self because of the dominant social narratives that exist in Aotearoa New Zealand society (Nairn & Coverdale, 2005). Diminished sense of self and self-worth could exacerbate the vulnerability of this already vulnerable population.

Sue’s clients are among the most vulnerable people in society. Without Sue’s help, many of these people would not actually receive social welfare,

housing, and healthcare entitlements. This situation reflects the ‘inverse care law’ (Hart, 1971). The inverse care law explains the inefficiencies and injustices of healthcare in free-market societies. It outlines how those with the highest level of need often receive the least amount of care, while people with a lesser need tend to monopolise the greatest share of resources. Although the inverse care law has predominantly been applied to healthcare the principles of the inverse care law are applicable in other social services as well. Often those that are most vulnerable are likely to receive the least amount of support or resources. Sue’s quote illustrates how the people she supports, who are part of one of the most vulnerable populations, feel unable to access support or resources without an advocate due to feeling marginalised and having low self-worth. The need for advocacy to acquire necessary support in Work and Income has been previously documented in Aotearoa New Zealand and in the earlier discussions about Andrew’s experiences (Hodgetts, Chamberlain, et al., 2014; Morton et al., 2014). The resultant marginalisation, reduced self-worth, and negative social narratives of people who experience mental illness or who live in poverty all reduce agency and voice. Additionally, people who experience mental illness are often overlooked as they may struggle to fully communicate their needs to agencies (Kelly, 2006). People with acute mental illness are often the most vulnerable and most in need of help, but are unable to communicate their needs. Consequently, their needs are not met, creating a cycle of despair, reducing self-worth and trust in services (Kelly, 2006).

If a person does not receive the required support to meet their needs from agencies, they may experience food, housing, or income insecurity. Food, housing, or income insecurity can contribute to personal insecurity in people’s lives, which is highlighted in Sue’s quote where she said “where do you fit into

society?”. This is an interesting reflection of the insecurities that are faced by people who experience mental illness or homelessness. People who experience mental illness or homeless often experience food, housing, and income insecurity. Their insecurity contributes to them becoming part of the precariat. The precariat is a grouping of society who lives in precarious life conditions, experiencing food, housing, and income insecurity (Standing, 2016). They are often unemployed or underemployed and are more transient than the general population due to this income insecurity. The precariat are often excluded from society and resources through design of society’s structures and institutions. Society and resources are designed for a domiciled existence; those who live outside of this domiciled lifestyle do not “fit” within the boundaries of this life (D. Johnson et al., 2013). The design of resources and society excludes homeless people and often contributes to them feeling that they do not fit in or belong. An example of resources that are designed for middle class norms and needs is an online application system that has recently been implemented for Work and Income (Aotearoa New Zealand Welfare System). The introduction of online services will not suit everyone, by providing a variety of ways to deliver services there is a higher chance of meeting people’s diverse needs. If you do not have access to internet, are not computer literate, and are unable to travel to the Work and Income offices to use their computers due to illness, location, or finances then applying, renewing, or updating benefits becomes near impossible. The design of resources and society based on the assumption that all people have such resources and capabilities is a form of social exclusion, since it reduces the ability of people who experience homelessness or mental illness to fully participate (Corrigan et

al., 2003). It is important to ensure that there are resources and systems in place to support everyone's right to fully participate in life.

Sue also raised a rights-based argument when she says “how can I expect to stand up for my rights here”. Sue's statement suggests that her clients' often need to strongly advocate for their rights to receive full entitlements. In the case of Sue's clients who experience homelessness this statement may be true. Rights based arguments exist for the prevention of homelessness, because of the poor health that is associated with homelessness and the significantly reduced life expectancy of people that live on the streets, these arguments suggest that homelessness is a violation of a person's human rights (Berghs, 2014; Rasanathan, 2010). Dominant social narratives need to be challenged so that they extend to include the view that a life without discrimination and having access to housing are both fundamental human rights (Rasanathan, 2010).

In the mental health system, clients are not always given choice over the services they receive. Sue was discussing this same lack of choice in residential services where clients are forced to share accommodation with a roommate that is selected by the staff. This imbalance was reflected when Sue spoke about:

“Humanity doesn't work like that. We don't. We're tribes, we're families, we're groups of friends. But we choose. And if you're in a tribe you don't necessarily have to associate with someone you don't like within that group of people. But when you're in residential service or when you're in hospital, you don't have no choice buddy.”

Sue's narrative makes reference to the conditions that are forced on those who have mental illness that they have little choice or control over. Often, for people

who experience mental illness or poverty, there is an imbalance in the choice and control that they have over their lives. Furthermore, historically people who have experienced mental illness have in fact had methods used to control them and their behaviour through the use of medicalization (Schneider, 2010). Earlier in this chapter and in the introduction chapter, choice was discussed in the context of the principles of deinstitutionalisation. Although the process of deinstitutionalisation did in fact give more choice to mental health clients, at times the current mental health services still functions to remove choice and assert control over clients. This is particularly so in the case of Sue's clients who experience acute and enduring mental illness and can be required legally to receive treatment under a community treatment order (Newton-Howes, Lacey, & Banks, 2014). Although community treatment orders are focussed on the individual, more broadly people who have mental illness also experience limited choice due to a variety of factors including lack of political representation; exclusion from full participation in civic, social and political life; difficulties identifying or communicating their needs; and ineffective health services (Kelly, 2006; Morton et al., 2014).

Sue's clients often experience poverty, the impacts of this on their health is discussed below. However, in her quote above Sue discusses the limited choice that her clients experience. This is due to the mental health system, as discussed above, but could also be related to their poverty. People who are poorer have fewer options, therefore less choice, because they do not have the financial resources to pay for alternative options. For example, Sue is talking about residential care services where people are expected to share housing with people and do not get to choose who they share with. These residential services are run

by NGO and are often subsidised so they are cheaper than private accommodation (A. Johnson, 2017b). If the person is not able to afford to move, they then have no choice but to live with someone who they may not like. When both poverty and mental illness are combined, as they are in the case of the participants and Sue's clients, then their choice and control is limited even further (Topor et al., 2014).

4.3 Social determinants of health

Social determinants of health have a large impact on people who experience mental illness and homelessness (Sederer, 2016). This population is particularly impacted by economic stability and poverty as well as housing instability, unemployment, adverse childhood events, food insecurity, and discrimination. In her interview, Sue discusses poverty and how that affects people:

“There's always going to be a sector of society who are affected by poverty and the resultant things about that, whether it comes to physical health or mental health. Those are going to go hand in hand.”

In Sue's role as a social worker, within an acute mental health team in Aotearoa New Zealand, she is exposed frequently to poverty. In her quote above, Sue links this poverty closely with poor mental and physical health. Poverty can be defined as “a lack of resources which leads to not being able to maintain basic human needs or a minimum standard of living” (Boston, 2018, p. 28). Studies suggest that in 2018, 27% of Aotearoa New Zealand's population live in relative poverty (Boston, 2018, p. 30). It is well recognised that poverty and both mental and physical poor health are connected, so Sue's statement that poverty comes “hand in hand” with poor health is very accurate (Marmot, 2005).

As a member of the OECD, Aotearoa New Zealand is a relatively wealthy country, which means there should be adequate resources for all citizens (Rashbrooke, 2013). Perhaps the solution lies in sharing these resources more. Poverty rates differ across developed countries, which suggests that the policies that exist within each country do impact on poverty, and therefore poverty can be reduced (Boston, 2018). Countries that have lower rates of poverty have lower than average levels of income inequality, and have more effective tax-welfare systems that redistribute resources to lower income households (Boston, 2018). Over the last 30 years, there have been rapidly growing inequalities in Aotearoa New Zealand, and this has resulted in a reduction of the middle class as more and more people fit within the criteria of either the wealthy or the poor (Rashbrooke, 2013). The impacts of growing disparities are far-reaching, and are often linked to decreased wellbeing, social capital, and happiness (Wilkinson & Pickett, 2010). Because of their lack of resources, people who live in poverty are often marginalised and socially excluded. Sue discussed this marginalisation and lack of resources in her interview:

“People are so depleted, so marginalised that they feel as though they've run out of resources, so it's not going to change.”

In her quote, Sue also suggest that her clients' experiences of poverty and marginalisation have impacted on them to the point where they feel their resources are depleted. This differs from the dominant social narratives about poverty, which accuse people who are in poverty of being lazy or personally lacking (Jeppesen, 2009; Lawson, 2012). Furthermore, a study completed by Amundson, Zajicek, and Kerr (2015) discovered that mainstream narratives about the poor often depicted them as having drug issues. The existence of negative

social narratives about the poor provide a justification for exclusion from social life, and thus further disadvantage a group that is already disadvantaged (Lawson, 2012). Sue's clients have experienced this exclusion and marginalisation, and her quote reflects the frustration and empathy that she feels for them.

Sue's quote suggests that people who are poor or disadvantaged struggle to improve their circumstances due to their depleted resources and marginalisation. More specifically, Sue is speaking about her mental health clients who live in poverty and may periodically experience homelessness. Their life circumstances continue to disadvantage them and make it very difficult for them individually to improve their life circumstances. Poverty has been described by many as a "trap", and can be a particularly hard situation for people who experience disabilities to escape (Stapleton, O'day, Livermore, & Imparato, 2006). Furthermore, poverty and homelessness are wider than any individual and are largely caused by political and economic factors. Accordingly, there should not be an expectation that an individual can and should be able to solve these complex issues themselves, instead the state should take responsibility (Boston, 2018; Parsell & Marston, 2012).

4.4 Solutions

Many solutions have been proposed and implemented over time to try and solve homelessness (Chernega & George, 2014). Luke and Sue both had differing views about the best solutions for homelessness. In particular, Luke and Sue had divergent views about the use of boarding housing. Sue says:

“I don't like boarding houses, there seems to be an accumulation of people of a similar bent because they're low income, probably often mentally unwell, often not untreatable but poorly treated.”

Sue's quote acknowledges the “accumulation” of people with low income and mental illness in boarding houses or shelters. Boarding houses are usually used as a low cost emergency housing option for people who have a low income (Anderson, 2016). In Australia, researchers have linked the cluster of people with mental illness living in boarding houses to the process of deinstitutionalisation (Drake, 2014). People who had previously been housed in institutions were forced to find new accommodation with little support. The lack of planning for new accommodation caused “transinstitutionalisation” or the process of people being transferred from psychiatric institutions to boarding houses due to the low cost and availability of boarding houses (Drake, 2014). Boarding houses thus became poorer staffed institutions with reduced access to health services for the people who moved there. The link between people in boarding houses not receiving adequate health services and subsequently having poorer health outcomes was highlighted in the same Australian study aforementioned (Drake, 2014).

Although boarding houses can have poorer health outcomes, they still help to prevent people from sleeping rough. Luke explains that a well-run boarding house can reduce rough sleeping:

“I think a boarding house that was managed... but also to make sure that they pay their rent, to make sure that they're not excessively drinking, I'm not saying that they shouldn't drink but all those kinds of things. What I find is when they come here we have to have rules, we have to have

ground rules, otherwise it would be chaos you know. And they actually adapt quite easily to them and it actually gives them a feeling of safety as well.”

Like most ‘solutions’ for rough sleeping there are both pluses and minuses. It also depends on how a particular boarding house or shelter is managed. In the end, having people indoors is most likely to be helpful – even if it is just to ensure that they are not subjected to the elements and the high rates of violence rough sleepers often endure. As a society, we should be looking at options that help people to live better lives over the longer term, rather than encouraging the use of individualistic interventions, which may work short term but do not address the underlying causes. Another intervention that has been introduced in Hamilton recently is Housing First. Luke discussed the effectiveness of this intervention in his quote below:

“Some of those people that were assessed are coming back as well so it [The People's Project- Housing First Initiative] wasn't a long-term solution. It looks good on the books but how long lasting is it going to be you know.”

Housing First has been discussed in the introduction chapter as one of the commonly used responses to homelessness. Luke’s quote above demonstrates that housing people and making no other changes is not a “long-term solution”, since it does not address the complexity of homelessness. Homelessness is not just caused by a lack of housing, so cannot be solved without also addressing poverty, discrimination, and structural violence (Farrugia & Gerrard, 2016; Hodgetts, Chamberlain, et al., 2014; Hodgetts et al., 2012).

Luke's quote is an interesting reflection about the number-based targets that are used by agencies to try and show the public that action is being taken. The number of people that have been housed may look "good on the books", but it should be the long-term effectiveness of a solution that it is worth is measured on. Focussing on quick answers could be reflective of social narratives that create the impression that agencies are being proactive and addressing homelessness when in reality people are just being moved around which reduces their visibility.

4.5 Summary

This chapter has focussed on the narratives of two of the participants who work almost daily with people who experience homelessness. Their narratives have mainly focussed on barriers to maintaining accommodation and how this impacts on people's lives. These barriers included deinstitutionalisation and the lack of planning and resources put into transitions into community living, and how this creates vulnerability to homelessness; the societal imbalances that limit control and choice for people who experience homelessness and mental illness; the social determinants of health and how these should not be seen as inevitable or unchangeable; and suggested solutions. All of the barriers that were discussed could be summarised by saying that not one thing causes homelessness. Consequently, there is a need to acknowledge the complexity of homelessness and the impact that the socio-political environment has on homelessness.

Chapter Five: Discussion, conclusions and future research opportunities

For this study, I set out to explore the barriers that people with mental illness face when attempting to find, sustain, and maintain accommodation. Through my research, I had the opportunity to talk with seven inspiring participants who, despite facing challenges daily, were optimistic about the future and open to sharing not only their stories about homelessness and mental illness, but also stories about their personal lives.

This chapter will begin by discussing reflections about the thesis aims and methodology. The chapter goes on to a short justification of the importance of personal narratives for understanding the experiences and lifeworlds of participants. I will then argue for the need to address structural barriers to housing, including the housing shortage and punitive welfare approaches. Following this, I will discuss the need to challenge dominant social narratives that reinforce mental health stigma and discrimination. Next, I will argue the importance of focussing on preventative action to address homelessness. Lastly, I will discuss areas for future research.

5.1 Reflections

The current study aimed to look at the barriers to gaining and sustaining housing for people who experience mental illness and have had a period of homelessness within the previous two years. My aim was to explore the interactions between housing, mental health, and homelessness. Whilst much literature exists that explores homelessness and mental health, often the implications of housing policy are not considered. Through widening the lens of this study to consider each

participants' unique life story and the socio-political environment in which they live, I was able to gain a better understanding of not only the obvious barriers to accommodation but also the wider contextual barriers. The humanistic psychology principles that underpinned the current study helped to encourage this wider understanding of participants' stories. Furthermore, the combination of humanistic psychology principles and narrative analysis helped to focus my understanding on each individual participant whilst not isolating them from the world in which their personal narratives were constructed.

5.2 Personal narratives

In the current study, the homeless participants all spent part of the interview building their narratives to include other parts of their biographies. Their narratives demonstrated the participants' intention to be seen as more than their circumstances. The willingness of participants to share their personal biographies acts as a very important reminder that people who experience mental illness or homelessness, should be given the opportunity to construct their own personal narratives (Rappaport, 2000). Consequently, it is likely that people who experience homelessness or mental illness may be empowered by the process of constructing their own narratives based on what is important to them personally (Nairn & Coverdale, 2005). The construction of personal narratives is especially important given that many systems, such as mental health, housing, and welfare services, are devised on the basis of overly reductive and generalised understandings of issues and people's needs (Lydia, 2014).

It is important to highlight the diversity of people who experience mental illness and homelessness in wider public discussions of such issues (Mills et al., 2015). Not all people will have the same life path or suit the same solutions.

Acknowledging the diversity and giving people the ability to construct their own narratives, as Tane requested in his interviews, is one way to challenge mainstream stories about people who have mental illness. Furthermore, challenging mainstream narratives about people with mental illness or who are experiencing homelessness also allows people to regain their agency (Rappaport, 2000). In essence, mainstream narratives are often maintained through passivity. Given this point, rebuilding the narratives about mental illness and homelessness will require action from society; in particular, from people who work within mental health as they will need to begin challenging their own narratives about the people they work with to reflect a more humanistic perspective (Sercu & Bracke, 2016).

5.3 Addressing structural barriers

In discussions about mental health and homelessness it is nearly impossible to not acknowledge the impacts that the history of deinstitutionalisation has had on mental health and homelessness (Dear & Wolch, 2014). The use of large scale institutions within mental health services was discontinued in the late 1990s (Brunton, 2003). Although these institutions were not always positive environments for the people who lived in them, the deinstitutionalisation process came with new challenges. The new challenges, of particular interest to this study, relate to the transition from institutions to the community care model and whether there are currently enough resources provided and whether the community care models are designed in an effective manner for mental health care.

Service design and delivery should be accessible to people from all walks of life (Morton et al., 2014). In particular, services should be accessible to those who they are there to serve. In the case of housing, welfare support (WINZ), and

mental health services, the inclusion of the voices of people from marginalised groups, like those who experience homelessness and mental illness, are necessary (Bessant & Maher, 2009). In future, better service design could prevent people from losing their agency or voice through inability to access services and receive adequate support. Many of the participants in this study discussed how services (housing and welfare) were hard to access, and that this could reduce service users' sense of self-worth. Furthermore, there has been longstanding acknowledgement that services, in particular health services, tend to benefit those with less need whilst those most in need do not receive the same level of care. This was discussed by Hart (1971), in his theory the 'inverse care law', which reflects that the poor design of services results in less care for people with the highest need for it. Hart's inverse care law was reflected in the current study where the participants in group 1 had inequitable access to services due to their homelessness, lack of resources, poverty, and health concerns all of which contributed to make accessing services harder. These participants had high needs for services, in particular welfare and housing support services, but often did not receive enough support or care. However, services are not the only intervention that should be considered when addressing the structural barriers to housing.

A key intervention to addressing a structural barrier to sustained housing could be an increase of social housing stock (A. Johnson et al., 2018). Increases in housing stock could improve the opportunities for vulnerable populations to find and sustain housing as there would be more houses available. Furthermore, if the housing stock was increased then this would take pressure off the rental market, which would then decrease rents through less competitive markets for tenants (A. Johnson et al., 2018). Although none of the participants talked much about their

struggles with finding private accommodation, they did speak about the affordability of rental prices being a barrier to gaining accommodation. Furthermore, they discussed the debt circle that would be created if they rented accommodation at a price that was unsustainable. Affordability and sustainability of housing should be a key focus to help reduce homelessness (Salvi del Pero et al., 2016). As well as increasing housing stock to make housing more affordable, there could also be a focus on not decreasing the social housing stock any further.

In the last five years, Aotearoa New Zealand's social housing stock has been reduced and there have been suggestions that this state resource should be transitioned to NGO management (A. Johnson, 2017b). Social housing has traditionally been used to help and protect people that are vulnerable because of their low income, family situation, or disability (Mills et al., 2015). There has been a growing number of people that fit into the criteria for social housing from 2014-2016 (Ministry of Social Development, 2017b). Growth in the need for social housing should be reflected in the government's approach to managing these state assets. According to A. Johnson (2013), there may in fact be a growing need for social housing in Aotearoa New Zealand. In the context of this study, two of the participants had applications for social housing declined whilst they were experiencing homelessness. The participants' declined applications during a period of homelessness demonstrates how Aotearoa New Zealand's social housing system is currently unable to intervene in the acute crisis of homelessness. In future, Aotearoa New Zealand needs to develop resources to address the housing crisis, but there is also a need to have an approach that prevents the crisis (Chernega & George, 2014). In the case of people with

complex mental health conditions, the government needs to take greater responsibility for providing the basic human right and need for shelter.

The basic human need for shelter and the health impacts of homelessness both indicate the relevance of a human rights-based approach to addressing homelessness (Fletcher, 2017; Rasanathan, 2010; Sherry, 2014; World Health Organization, 2015). The impact homelessness has on health is reflected in the significantly reduced life expectancies that homeless people experience (Bellamy, 2014). In the interview with Sue, she spoke about how people often struggle to stand up for their own rights and consequently their rights are not met. Sue is a social worker with an extensive history of working with people with mental illness and who experience homelessness. She acts as an advocate for her clients so their rights are realised. As an individual, Sue's advocacy can only influence the people she has contact with. In Aotearoa New Zealand, we need to change the narrative to reflect a rights-based argument for addressing homelessness and to honour individual rights of service users. Changing social narratives is a slow process, but this can be accomplished through challenging the narratives that currently exist and critically examining their validity (Rappaport, 2000).

5.4 Reduction of stigma and discrimination

The pervasive mental health stigma that persists in society is now widely recognised (Livingston & Boyd, 2010; Sercu & Bracke, 2016). The current study highlighted that mental health stigma is still very present in society and found it had a significant impact on other areas of the participants' lives and in particular their housing. Notably, Karen and Tane's experiences of mental health stigma actively impacted on their housing, health, and social relationships. Karen and Tane experience stigma from their family members about their mental illness.

These experiences of stigma led them to their initial periods of homelessness and continue to impact on their ability to find and sustain housing. Stigma about mental illness not only impacts the housing of people with mental illness, but also impacts on their wider health and wellbeing as Māori. As reflected in Durie's (1984) Te Whare Tapa Wha model, health is not simply a matter of illness. Thus, mental illness and homelessness, are issues that need to be considered in terms of their impacts on their taha tinana (physical), taha wairua (spiritual), taha hinengaro (mental and emotional) and taha whānau (family) health (Livingston & Boyd, 2010; Rochford, 2004). Durie's Whare Tapa Wha model was reflected in the lives of my participants; taha tinana was reflected in Sue's stories about her client who experienced respiratory issues from years of rough sleeping; taha wairua was reflected when Andrew discussed his connection to his grandmother through her voice; taha hinengaro was reflected in all the participants' stories about striving for mental wellbeing; taha whānau was reflected when Tane and Karen discussed their fractured relationships with their family. Lastly, the importance of all of these pillars working together was reflected with Karen's journey to recovery and flourishing. With the right support she began renewing relationships with her son and mother, had achieved physical and mental wellbeing, and had built strong spiritual beliefs. For Karen to achieve this she also had to overcome the internalised stigma about mental illness that she had experienced.

The participants' narratives showed the impacts of their experiences of existing stigma about mental illness. Furthermore, the participants' narratives demonstrated how mental health stigma continues to have a significant impact on people's lives and on their housing. Mental health stigma also acts as a barrier for

people trying to access private housing (Mills et al., 2015). Despite landlords not being able to request health information from potential tenants legally, in the case of Sue's mental health clients', landlords still requested information about their mental illness. From these requests we can assume that stigma about mental illness can act as a barrier in the private rental market and could contribute to disadvantaging people with mental illness when it comes to gaining housing. Because of the negative impacts that mental health stigma can have on a person's housing, and more generally their life, it is important to reduce mental health stigma.

Stigma is created and maintained socially, therefore, it can be challenged and changed socially too (Claire et al., 1999; Nairn & Coverdale, 2005).

Challenging stigma could improve the lives of people who experience mental illness and decrease their chances of being negatively impacted by existing stigma (Rappaport, 2000). In particular, reducing stigma could improve the ability of people who experience mental illness to find, attain, and sustain housing and thus decrease their vulnerability to homelessness. Earlier in this chapter, the housing and social challenges that are created by existing stigma were discussed. Stigma can be challenged by giving people with lived experiences of mental illness more control over the narratives that exist about mental illness through letting them tell their stories and involving them in the design of services and social supports to help them live their best lives (Lydia, 2014; Sercu & Bracke, 2016).

5.5 Interventionist or preventative solutions

Housing First and shelters have been discussed as solutions to homelessness in the introduction and chapter four of this thesis. Historically, in Aotearoa New Zealand funding to address homelessness has focussed on emergency accommodation (A.

Johnson et al., 2018; Mackie et al., 2017). This appears to be the focus of the current Aotearoa New Zealand government, with Housing First initiatives receiving an increase in funding in the 2018/2019 budget (Robertson, 2018).

Whilst Housing First can help to improve the housing situation of individuals, it is only an ameliorative intervention that does not address the causes of homelessness therefore cannot solve it.

One of the participants, Luke, discussed concerns that the current Housing First intervention was not sustaining housing for its clients. The reasoning for this was not explored since assessing Housing First initiatives was not the focus of this study, but it does illustrate that there cannot be a single method implemented that will end homelessness. Studies in Australia have found that Housing First has been most effective for people with chronic mental illness when they have community care models of mental health and additional supports available (Holmes et al., 2017). Additional supports have been instrumental in the success of Housing First initiatives are emphasised in the principles of the Housing First model (Johnsen & Teixeira, 2010). Although Housing First has shown good results in many studies and maintains a 80% retention rate for people who have experienced homelessness it fails to end homelessness as it does not address the causes of homelessness (Johnsen & Teixeira, 2010; Mackie et al., 2017).

Homelessness is a complex social issue that cannot be solved by a focus on one single factor (Early, 1998). In the context of this study, the complexities of homelessness are stretched further when considering the life situations of people who experience homelessness combined with mental illness (Amore & Howden-Chapman, 2012). The complexities of homelessness have been acknowledged in extensive research, and are reflected in the policy development for prevention of

homelessness in Australia (Parsell & Marston, 2012). Despite this acknowledgement of the complex and structural causes of homelessness the social narratives, largely based on a neoliberal orientated political system, still seem to focus on an individual deficit models (Parsell & Marston, 2012). If there is truly going to be an end to homelessness, then the structural causes of homelessness, for example poverty, will need to be addressed and remain a focus of policy for prevention in the future (Hodgetts, Stolte, et al., 2014).

The social determinants of health are crucial to improving the health of all people (Wilkinson & Marmot, 1998). Therefore, taking an approach to homelessness and mental health that considers the importance of the social determinants of health is key to health improvements (Sederer, 2016; Silva et al., 2016). The two most important social determinants of health, when considering mental health and homelessness, are housing and poverty. Housing is obviously related to homelessness, but it is also related to improved mental and physical health through the physical and emotional safety that can be provided by a house (Isogai, 2016; Yanos et al., 2004). However, a focus on poverty reduction is also crucial in improving both mental health and homelessness. As discussed by Sue, one of the key issues for people who experience housing and mental health concerns is poverty. Due to the nature of poverty, people who experience it are also subject to social exclusion and poorer living conditions because of the material deprivation associated with poverty (Jeppesen, 2009; Watson et al., 2016). This same material deprivation makes it near impossible for people who live in poverty to intervene individually. Consequently, poverty needs to be addressed at a national level, and the reduction of poverty would provide great benefits in health, education, crime, and homelessness outcomes (Boston, 2018).

As is discussed above, homelessness is a complex issue that will need a specific focus on the improvement of the social determinants of health to address and prevent it. To do this, the Aotearoa New Zealand government needs to consider developing a comprehensive system-wide policy to address homelessness (Early, 1998). In Australia, the government developed policy in 2008 that addressed primary, secondary, and tertiary prevention (Parsell & Marston, 2012). Primary prevention focusses on addressing the structural barriers to homelessness like low housing stock and poverty rates. Secondary prevention focusses on services that intervene early when people are experiencing housing instability. The tertiary services are the rehousing and housing crisis services (A. Johnson et al., 2018). New Zealand currently puts most of its effort into tertiary services for homelessness. If New Zealand developed a comprehensive approach to homelessness, it would create better opportunities to prevent homelessness before it occurred.

5.6 Future research opportunities

An interesting area for further research would be to consider mental health stigma, in particular research on the consequences of families who discriminate against family members because of mental health stigma. All of the participants encountered some form of stigma about their mental health concerns. The most extreme cases of this were for Karen and Tane who were impacted the most by stigma and discrimination from their families. Both Tane and Karen are thirty-two, so their experiences of stigma in their late teens are now approximately fifteen years ago. Future research could explore whether people who are experiencing first period psychosis now have encountered similar stigma and discrimination from their family. Participants could then be interviewed again five

years later to see whether higher levels of familial stigma is linked with negative narratives about their experiences of living with mental health.

Homelessness, and the interventions to address homelessness, have been predominantly researched in countries like the United States of America, the United Kingdom, or Australia (Mackie et al., 2017). Although some of the findings from overseas studies will still be applicable to Aotearoa New Zealand, it would be beneficial for more research to be based here in order to consider the current homelessness situation. Although homeless populations have traditionally been perceived as people that sleep rough, or people that live in public spaces, the meaning of homelessness has now expanded to include the hidden homeless, which includes those couch surfing, or living in overcrowded housing (Statistics New Zealand, 2009). In Aotearoa New Zealand, we need to have a clear appreciation of where the homeless population is based, so that we can better understand actions that could be taken to prevent homelessness. Furthermore, there is a need to critically evaluate the interventions that are being implemented to address homelessness in Aotearoa New Zealand to see whether government actions are making a difference. In particular, there is a need for a wider public debate to make sure that the government's actions are helping to remove barriers to sustainable housing for people who experience mental health concerns and are vulnerable to homelessness.

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Appendices:

Appendix A:

Housing, mental health and homelessness

Letter of Invitation: Group 1

Email to community mental health clinicians:

Hello,

My name is Cait and I am a support worker in the Crisis team. I am currently doing my masters thesis through the University of Waikato on 'Housing, Mental Health and Homelessness'.

I have attached a letter of invitation to this email. If you know of anyone who has experienced a period of homelessness (this can include a period where they are couch surfing with friends/family) in the last two years, is currently well and might be interested in sharing their experiences of trying to find accommodation please share my letter of invitation with them.

Cait Cresswell

Ph: 021 815 713

Attached letter of invitation:

Dear potential participant,

My name is Cait and I am a masters student from the University of Waikato and a support worker with the Waikato DHB. I am currently doing a study on 'Housing, Mental Health and Homelessness'. I have chosen this topic for my masters as I think it's very important for us to better understand how housing impacts on homelessness.

If you are a person who has experienced a period of homelessness in the past two years, who has mental health concerns and would like to talk about your experiences of trying to find housing I would very much like to speak with you. The process will involve an interview of approximately one hour and a brief follow up interview of approximately 15-30 minutes.

The research aims to explore experiences of homeless people with mental health concerns in trying to find accommodation; to explore staff experiences of trying to find homeless people with mental health concerns accommodation, and to examine current housing policy in New Zealand and other OECD countries. The overall goal of the research is to establish what is needed in order to ensure that people with mental health concerns do not become homeless.

Please contact me if you would like more information about the study. You are able to contact me through your community mental health worker at London Street or through the contact details supplied below.

Thank you for your time,

Cait Cresswell

Email: cgc10@students.waikato.ac.nz

Ph: 021 815 713

Appendix B:

Housing, mental health and homelessness Information Sheet: Group 1

What is this study about?

This study explores the experiences of people with mental health concerns of trying to find accommodation. I am interested in learning more about your personal experiences of finding housing either for yourself or for someone that you have supported to find accommodation.

Who is conducting the study?

Cait is a student from the University of Waikato who also works with the Waikato DHB as a support worker. The research will be supervised by two staff members from the University of Waikato Otilie Stolte and Mohi Rua. This research is approved by the School of Psychology Ethics committee at the University of Waikato and the Waikato DHB ethics committee.

Who can take part?

You can take part in this study if you have mental health concerns and are currently homeless or have had a period of homelessness within the last two years. You are able to bring a support person to be there during the interview but please inform the researcher before the interview when you are organising a time and place.

What will I be asked to do?

This study is in two parts.

First, you will be asked to meet for an initial interview which will take about an hour. The first interview will cover your history; how it is being homeless; your experiences of finding accommodation; your relationships with agencies; a brief discussion of mental health concerns; your connections to people and place; people's perceptions and media portrayal of homelessness and any future plans you have. If there are any questions in the interview that you do not feel comfortable answering you do not have to answer them and may choose to decline to answer.

You may bring a support person with you to the interview but please tell the researcher beforehand. The place of the meeting will be decided upon by yourself and the researcher while you are organising it. You will receive a \$20 koha at the end of the interview for your time.

Second, the researcher will plan to catch up with you approximately a week after your first interview for a second meeting. The purpose of this is to give you an opportunity to think about what we've discussed and for you to expand on anything that you'd like to discuss further or ask questions about.

What can I expect from the researcher?

You can:

- ask questions at any point during the study

- contact your key worker who initially approached you if you have any concerns or you can contact the people listed at the end of this document.
- withdraw your consent to take part in the study up to a month after the second interview.
- ask for the audio recorder to be turned off at any point during the two interviews
- expect that the information will be kept confidential to the researchers and information in the report will be anonymised but that you might be identifiable to those who are familiar with your history and views.
- expect a copy of your interview transcripts to be made available to you within two weeks of your interview so that you can make corrections or changes.
- expect us to make the general research findings available to you through a contact method of your choosing.
- expect us to give you a reasonable reimbursement of travel costs for coming to meetings.

If you have any further questions or concerns regarding this study please do not hesitate to contact:

Cait Cresswell
021 815 713
cgc10@students.waikato.ac.nz

Supervisors:

Otilie Stolle
(07) 838-4466 Ext. 9231
ottilie@waikato.ac.nz

Mohi Rua
(07) 838-4466 Ext. 9213
mrua@waikato.ac.nz

This research project has been approved by the School of Psychology Research and Ethics Committee of the Faculty of Arts and Social Sciences, University of Waikato. Any questions about the ethical conduct of this research may be sent to the convenor of the Research and Ethics Committee (currently Dr Rebecca Sargisson, phone 07 557 8673, email: rebeccas@waikato.ac.nz)

Appendix C:

Housing, mental health and homelessness

Letter of invitations: Group 2

Email to service providers:

To whom it may concern,

My name is Cait and I am studying at the University of Waikato and a support worker with the Waikato DHB. I am currently doing a masters thesis on 'Housing, Mental Health and Homelessness'. I have chosen this topic for my research as I think it's very important for us to better understand how housing issues impact on homelessness.

As part of my research I would like to interview a staff member from your service. This staff member must have experience finding accommodation for a person with mental health concerns who has been homeless recently (in the past two years).

I have attached to this email an information sheet about the study and a letter of invitation for any staff members that fit the above criteria. Please contact me if you have any further questions or would like anything clarified.

Thank you for your time,

Cait Cresswell

Ph: 021 815 713

Attached letter of invitation:

Dear potential participant,

My name is Cait and I am studying at the University of Waikato and a support worker with the Waikato DHB. I am currently doing a masters thesis on 'Housing, Mental Health and Homelessness'. I have chosen this topic for my research as I think it's very important for us to better understand how housing issues impact on homelessness.

The research aims to: 1) explore the experiences of homeless people with mental health concerns in trying to find accommodation; 2) to explore staff experiences of trying to find accommodation for homeless people with mental health concerns; and 3) to examine current housing policy in New Zealand and other OECD countries. The overall goal of the research is to

establish what is needed in order to protect vulnerable populations from becoming homeless.

If you have experience supporting people to find accommodation who have had a period of homelessness in the past two years, and would be happy to discuss the experience with me, please contact me. The process will involve an interview of approximately one hour. This can be done in a place and time convenient to you.

Please contact me if you would like more information about the study.

Thank you for your time,

Cait Cresswell

Email: cgc10@students.waikato.ac.nz

Ph: 021 815 713

Appendix D:

Housing, mental health and homelessness

Information Sheet: Group 2

What is this study about?

The research aims to explore the experiences of homeless people with mental health concerns of trying to find accommodation; to explore staff experiences of trying to find homeless people with mental health concerns accommodation and to examine current housing policy in New Zealand and other OECD countries and how this can protect vulnerable populations from becoming homeless.

Who is conducting the study?

Cait is a student from the University of Waikato who also works with the Waikato DHB as a support worker. The research will be supervised by two staff members from the University of Waikato Otilie Stolte and Mohi Rua. This research is approved by the School of Psychology Ethics Committee at the University of Waikato and the Waikato DHB ethics committee.

Who can take part?

There are two different groups being asked to take part in the study. There will be 6-8 people involved who have recently (in the last year) experienced a period of homelessness who have mental health concerns. There will be another group where a staff member from the Waikato DHB, Anglican Action or Methodist City Action who have supported a person who group 1's criteria will be asked about their experience of trying to find someone accommodation. You are able to bring a support person to be there during the interview but please inform the researcher before the interview when you are organising a time and place.

What will I be asked to do?

This study is in two parts.

First, you will be asked to meet for an initial interview, this will take about an hour. The first interview will cover your career history; your impressions of homelessness; your experiences of finding accommodation; relationships with agencies; a brief discussion of how mental health concerns might impact accommodation; connections to people and place; people's perceptions and media portrayal of homelessness and a discussion of the future of homelessness. If there are any questions in the interview that you do not feel comfortable answering you do not have to answer them and may choose to decline to answer.

The place of the meeting will be decided upon by yourself and the researcher while you are organising it.

Second, the researcher will plan to catch up with you through email approximately a week after your first interview. The purpose of this is to give

you an opportunity to think about what we've discussed and for you to expand on anything that you'd like to discuss further or ask questions about.

What can I expect from the researcher?

You can:

- ask questions at any point during the study
- you can contact the people listed at the end of this document.
- withdraw your consent to take part in the study up to two weeks after the second interview.
- ask for the audio recorder to be turned off at any point during the two interviews
- expect that the information will be kept confidential to the researchers and information in the report will be anonymised but that you might be identifiable to those who are familiar with your role and views.
- expect us to make the general research findings available to you through a contact method of your choosing.

If you have any further questions or concerns regarding this study please do not hesitate to contact:

Cait Cresswell
021 815 713
cgc10@students.waikato.ac.nz

Supervisors:

Otilie Stolte
(07) 838-4466 Ext. 9231
ottilie@waikato.ac.nz

Mohi Rua
(07) 838-4466 Ext. 9213
mruea@waikato.ac.nz

This research project has been approved by the School of Psychology Research and Ethics Committee of the Faculty of Arts and Social Sciences, University of Waikato. Any questions about the ethical conduct of this research may be sent to the convenor of the Research and Ethics Committee (currently Dr Rebecca Sargisson, phone 07 557 8673, email: rebeccas@waikato.ac.nz)

Appendix E:

Housing, mental health and homelessness

Initial Interview: Group 1

Introduction

The interview process will be loosely structured to allow for building of rapport and natural discussion of topics. There will be an initial introductory period where participants will be offered food as a way to connect.

The aims of the research and first interview will be explained to participant:

- to get to know you and for you to learn about who I am. This is to make you feel more comfortable with the process
- to learn about your experiences of homelessness and trying to find housing
- please think of this as an informal chat about your experiences and try to relax and answer honestly. If you have any questions or want me to explain further please feel free to ask me
- Confidentiality explained

History of homelessness

- Can you tell me about any times in the past where you would have described yourself as being homeless? Prompt: Homelessness can also include time couch surfing with family/friends or other periods where you've had unstable/temporary housing.
- When was your most recent period of homelessness?
- Can you tell me more about how you became/become homeless?
- What would you say are the main causes of homelessness?

Being homeless

- What is the thing you worry most about when you are homeless?
- (If not accommodation and safety) how does accommodation fit into your list of worries?
- Do you think homelessness affects your health? How?
- What do you do to keep yourself going on a day-to-day basis?
- How do you overcome challenging situations?
- If you were to summarise what it's like to be homeless what would you say?

Finding Accommodation

- How have you found getting accommodation after a period of homelessness?
- How long have you spent trying to find accommodation?
- When/if you've found accommodation could you please describe why/why not you've stayed?
- How does the price of accommodation affect your search?
- How does the condition of accommodation affect your search?
- What kinds of accommodation do you think would suit you best? (group homes, private flat, flatting with friends, supported accommodation, private accommodation, HNZ accommodation)

Relationships with agencies

- Did you get any assistance with finding accommodation? How did you find this assistance? Was it helpful/disempowering?
- Have you lived in private housing or HNZ? If one please describe your relationship with your landlord? If both could you please describe the differences between living in each type of accommodation (including landlord)?
- Have you ever been asked about your personal health information by a landlord or rental agency?
- Have WINZ helped you with accommodation in the past?
- Can you describe any interactions you may have had with WINZ? E.g. debt gained from bonds given for unsustainable accommodation.

Mental Health

- Are you happy to talk about your mental health concerns? (Remind of confidentiality)
- Just to remind you if there are any questions you do not feel comfortable answering that is absolutely fine.
- When did you first have contact with mental health services?
- How would you describe a period of wellness for you?
- What things help to keep you well?
- What things have contributed to making you become unwell in the past?
- Do your mental health concerns affect your housing? If yes how so?

Connections

- Who are the people that are important to you?
- Has your relationship with these people changed since you became homeless or housed? How?
- How do your feelings of being a part of the community change when you have transitioned from homeless to housed or vice versa?

Perceptions and media portrayal

- Do you think people's perceptions of you changes when you have moved from homeless to housed or vice versa? How?
- Does your perception of yourself change when you move from homeless to housed or vice versa? How?
- How does the media portray people who are homeless?

Futures

- What would you like to be doing in two or three years time?
- How might you get there?
- Who or what will be important in this?

Closing the interview

Summarise the main points from the interview and encourage further input from the participant.

- Would that be an accurate synopsis?
- Is there anything you would like to bring up or thought should have been discussed?
- Do you have any questions concerning this study?
- Give contact details and ask for preferred contact method.

Housing, mental health and homelessness

Second Interview: Group 1

Introduction

1. Talk with the participants and explain the aims of the second interview. This interview is:
 - To see if you have thought of anything else that you would like to add from our discussion in the first interview.
 - To give you the opportunity to ask questions that you might have thought of after the interview.
2. Again, you should approach this as an informal discussion.

Summary of first interview

Elaboration

- Are there any thoughts that you would like to add to our first interview?
 - Are there any questions that you would like to ask about the study?
- Give contact details and confirm preferred contact method.

Appendix F:

Housing, mental health and homelessness

Interview: Group 2

Introduction

The interview process will be loosely structured to allow for building of rapport and natural discussion of topics. There will be an initial introductory period where participants will be offered food as a way to connect.

The aims of the research and first interview will be explained to participant:

- to get to know you and for you to learn about who I am. This is to make you feel more comfortable with the process
- to learn about your impressions of homelessness and trying to find housing for clients
- please think of this as an informal chat about your experiences and try to relax and answer honestly. If you have any questions or want me to explain further please feel free to ask me
- Confidentiality explained

Career history

- What is your job title and what does it entail on a weekly basis?
- How long have you been in your field of work?
- How often do you interact with people who are homeless?

Being homeless

- What is the thing that worries your clients most when they are homeless?
- (If not accommodation and safety) how does accommodation fit into their list of worries?
- Do you think homelessness affects your client's health? How?
- If you were to summarise what it's like to be homeless what would you say?

Finding Accommodation

- How have you found getting clients accommodation after a period of homelessness?
- How long do you spend trying to find accommodation on average for a client?
- How do you overcome challenging situations?
- Why might people not stay in accommodation?
- How does the price of accommodation affect your search?
- How does the condition of accommodation affect your search?
- What kinds of accommodation do you think would best suit your clients? (group homes, private flat, flatting with friends, supported accommodation, private accommodation, HNZ accommodation)

Relationships with agencies

- Do you get any assistance with finding accommodation from external agencies? How did you find this assistance? Was it helpful/disempowering?
- Please describe your experiences with trying to find people private accommodation vs. HNZ housing? Are there any difference in the application process? Any differences in the questions asked about people's health?
- Have you worked with WINZ for accommodation in the past?
- Can you describe how your clients feel before going for an appointment with WINZ?

Mental Health

- Have landlords or rental agencies asked you about a client's personal mental health information during applications for housing?
- What things help to keep your clients well?
- What things contribute to making clients become unwell?
- Do your client's mental health concerns affect their housing? If yes how so?

Connections

- How do your clients perception of being part of the community change when they move from housed to homeless or vice versa?
- How does social connections support wellness in people with mental health concerns?

Perceptions and media portrayal

- Do you think people's perceptions of your clients change when they move from homeless to housed or vice versa? How?
- How does the media portray people who are homeless?

Futures

- The number of homeless people in Hamilton is increasing. How might this trend be changed?

Closing the interview

Summarise the main points from the interview and encourage further input from the participant.

- Would that be an accurate synopsis?
- Is there anything you would like to bring up or thought should have been discussed?
- Do you have any questions concerning this study?
- Give contact details and ask for preferred contact method.

Appendix G:**Housing, mental health and homelessness****Participant Background Sheet: Group 1****Interviewee Name:** _____

Date: _____

Duration of the interview: _____

Gender: **M** **F** Age: _____

Ethnicity: _____

Current housing status: _____

Additional information (including health issues, disability, marital status,
parenting, area of origin) _____

Family/whanau contacts? _____

Service agency

Location of the interview (brief description): _____

Charting the interview

Impression of the interviewee: _____

Impression of how the interview went: _____

Initial themes to emerge in the interview: _____

Potential revisions for the interview guide: _____

Synopsis: _____

Appendix H:

Housing, mental health and homelessness

Participant Background Sheet: Group 2

Interviewee Name: _____

Date: _____

Duration of the interview: _____

Gender: **M** **F** Age: _____

Ethnicity: _____

Current employment position: _____

Additional information _____

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's resting on a surface.

Location of the interview (brief description): _____

Charting the interview

Impression of the interviewee: _____

Impression of how the interview went: _____

Initial themes to emerge in the interview: _____

Potential revisions for the interview guide: _____

Synopsis: _____

Appendix I:



CONSENT FORM Housing, Mental Health and Homelessness

Please complete the following checklist. Tick (✓) the appropriate box for each point.	YES	NO
1. I have read the Participant Information Sheet (or it has been read to me) and I understand it.		
2. I have been given sufficient time to consider whether or not to participate in this study		
3. I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet		
4. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without penalty		
5. I have the right to decline to participate in any part of the research activity		
6. I know who to contact if I have any questions about the study in general.		
7. I understand that the interview is being recorded and that I may ask for the recording to be stopped at any time during the interview		
8. I understand that my participation in this study is confidential and every effort will be made to anonymise the information shared but there is a possibility that I might be identifiable to those who are familiar with my views and history.		
I wish to receive a copy of the summary of findings		
I wish to view the transcript of my interview, this will be returned to me within two weeks of this interview		
I consent to the researcher keeping anonymised interview transcripts in a password protected folder for future research		

Declaration by participant:

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Psychology Research and Ethics Committee (Dr Rebecca Sargisson, phone 07 557 8673, email: rebeccas@waikato.ac.nz)

Participant's name (Please print):

Signature:

Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name (Please print):

Signature:

Date:
